Appendix A
Systems of Care

Appendix B
Compliance and Confidentiality

Documentation Standards for Client Records

The documentation standards are described below under key topics related to client care. All standards shall be addressed in the client record; however, there is no requirement that the record have a specific document or section addressing these topics.

A. Assessments

1. The following areas shall be included as appropriate as part of a comprehensive client record.

- Relevant physical health conditions reported by the client shall be prominently identified and updated as appropriate.
- Presenting problems and relevant conditions affecting the client's physical health and mental health status shall be documented, for example: living situation, daily activities, and social support.
- Documentation shall describe client strengths in achieving client plan goals.
- Special status situations that present a risk to client or others shall be prominently documented and updated as appropriate.
- Documentation shall include medications that have been prescribed by mental health plan physicians, dosages of each medication, dates of initial prescriptions and refills, and documentation of informed consent for medications.
- Client self report of allergies and adverse reactions to medications, or lack of known allergies/sensitivities shall be clearly documented.
- A mental health history shall be documented, including: previous treatment dates, providers, therapeutic interventions and responses, sources of clinical data, relevant family information and relevant results of relevant lab tests and consultation reports.
- For children and adolescents, pre-natal and perinatal events and complete developmental history shall be documented.
- Documentation shall include past and present use of tobacco, alcohol, and caffeine, as well as illicit, prescribed and over-the-counter drugs.
- A relevant mental status examination shall be documented.
- A five axis diagnosis from the most current DSM, or a diagnosis from the most current ICD, shall be documented, consistent with the presenting problems, history, mental status evaluation and/or other assessment data.

2. Timeliness/Frequency Standard for Assessment

- The MHP shall establish standards for timeliness and frequency for the above-mentioned elements.

B. Client Plans

1. Client Plans shall:

- have specific observable and/or specific quantifiable goals

- identify the proposed type(s) of intervention
- have a proposed duration of intervention(s)
- be signed (or electronic equivalent) by:
  - the person providing the service(s), or
  - a person representing a team or program providing services, or
  - a person representing the MHP providing services
  - when the client plan is used to establish that services are provided under the direction of an approved category of staff, and if the above staff are not of the approved category,
    - a physician
    - a licensed/"waivered" psychologist
    - a licensed/registered/waivered social worker
    - a licensed/registered/waivered marriage and family therapist or
    - a registered nurse

- In addition,
  - client plans shall be consistent with the diagnoses, and the focus of intervention shall be consistent with the client plan goals, and there shall be documentation of the client's participation in and agreement with the plan. Examples of documentation include, but are not limited to, reference to the client's participation and agreement in the body of the plan, client signature on the plan, or a description of the client's participation and agreement in progress notes.
  - client signature on the plan shall be used as the means by which the MHP documents the participation of the client
    - when the client is a long term client as defined by the MHP, and
    - the client is receiving more than one type of service from the MHP
  - when the client's signature is required on the client plan and the client refuses or is unavailable for signature, the client plan shall include a written explanation of the refusal or unavailability
  - the MHP shall give a copy of the client plan to the client on request

2. Timeliness/Frequency of Client Plan:
   - Shall be updated at least annually.
   - The MHP shall establish standards for timeliness and frequency for the individual elements of the client plan described in item 1

C. Progress Notes

1. Items that shall be contained in the client record related to the client's progress in treatment include:

   - The client record shall provide timely documentation of relevant aspects of client care
   - Mental health staff/practitioners shall use client records to document client encounters, including relevant clinical decisions and interventions

- All entries in the client record shall include the signature of the person providing the service (or electronic equivalent); the person's professional degree, licensure or job title; and the relevant identification number, if applicable
- All entries shall include the date services were provided
- The record shall be legible
- The client record shall document referrals to community resources and other agencies, when appropriate
- The client record shall document follow-up care, or as appropriate, a discharge summary

2. Timeliness/Frequency of Progress Notes:

Progress notes shall be documented at the frequency by type of service indicated below:

a. Every Service Contact

- Mental Health Services
- Medical Support Services
- Crisis Intervention

b. Daily

- Crisis Residential
- Crisis Stabilization (1x/23hr)
- Day Treatment Intensive

c. Weekly

- Day Treatment Intensive: a clinical summary reviewed and signed by a physician, a licensed/waivered/registered psychologist, clinical social worker, or marriage and family therapist; or a registered nurse who is either staff to the day treatment intensive program or the person directing the service
- Day Rehabilitation
- Adult Residential

d. Other

- Psychiatrist health facility services: notes on each shift
- Targeted Case Management: every service contact, daily, or weekly summary
- As determined by the MHP for other services

Appendix C
Accessing Services

Adult and Older Adult
Mental Health Services

Provider:
Week of:

Request for Services Log 5.0

REVISED 5/03

	Initial Contact With Clinic							Appointment	
	Inquiry date	Name	TC WI	Question / problem	Res-ponse code	MH insur code	Ref-erral code	Dispo code	Mental Health Assessment appt date	Psychiatric Assessment appt date
1										
2										
3										
4										
5										
6										
7										
8										
9										
10										

*** TC = Telephone call WI = Walk in**

Response Codes

E = Emergent (emergency) - Life Threatening (access within 1 hour)
U = Urgent - At risk of becoming life threatening (access within 72 hours
H = Patient D/C'ed from inpatient program (72 hr rapid response assessmer
R = Routine - Meets medical necessity criteria (within 14 days for MH assessmer
I = Request for Information/referra

Referral Codes

1) Outpatient Mntl Hlth Clinic
2) Individual/Group Provider
3) Case Management Provide
4) Day Rehabilitation Progran
5) START Program
6) Psychiatric Hospita
7) Access & Crisis Line
8) PERT
9) EPU
10) Other--please specify

Mental Health Insurance Codes

NO = None
MC = MediCal
ME = Medicare
PT = Private Insurance
VA = Veterans Admin
PB = Probation/parole
CH = CHAMPUS
MM = MediCal & Medicare

Disposition Codes

1) Made appointment
2) Referred out for Routine services
3) Referred out for Urgent services
4) Made appt for Pt D/C'd from hospital (appt within 72 hrs
5) Referred out for non MH services
6) No appt or referral made

For assistance contact: **Paul Ellingsen 619-563-2785**

County of San Diego
Health and Human Services Agency (HHSA)

SERVICE AUTHORIZATION FORM INSTRUCTIONS

The purpose of Service Authorization Form is to request authorized scheduled interpreting services with contracted service providers and to verify that authorized scheduled interpreting services were provided **OR** cancelled and when they were cancelled.

The Service Authorization Form must be completed for each individual requiring interpreter services and authorizes services for one date only at the specified times and at a single location.

The form accompanying these Instructions dated 12/3/07 replaces all Service Authorization Forms previously in use to request interpreter services for clients/family members.

The Service Authorization Form may not be emailed with client information on it. A copy of the form may be provided to the interpreter if requested.

Note that oral interpreter services must be cancelled 24 hours in advance and American Sign Language (ASL) interpreter services must be cancelled 48 hours in advance. Please notify the client/family member of this requirement and ask them to contact your program in a timely manner if they need to cancel an appointment utilizing interpreter services. Services not cancelled timely will be charged to the County.

Instructions for Completing Section A:

- Select the Service Provider to be contacted by placing an "X" next to the Service Provider's name.
- Circle either "client" or a "family member" to indicate who is receiving the interpreter services.
- Provide the name of the person needing interpreter services and the date the services are required. If the person is under 18 years of age provide the age only, not the date of birth.
- Complete the chart by providing the type of appointment, language requested, begin time, end time and the name of the person requesting the service. Multiple appointments can be listed if they are on the same day and at the same location.
- Provide the agency name, program name and address or location of service site if not at the program address.
- Provide the name of the County department to be invoiced.
- Mental Health programs are required to indicate if the request is from a Children's program or an Adult program.
- Obtain Manager/designee approval signature to authorize the services requested. Manager/designee is required to provide signature, date, print his or her name and provide phone and fax numbers. Any questions about the delivered services or cancellations will be directed to the authorizing manager/designee.
- Call the selected service provider to verify availability of interpreter staff.
- **FAX the Service Authorization Form with Section A completed to the service provider selected to officially request interpreter services. Interpreter service will only be scheduled if service provider receives the faxed request with approval signature by the Manager/designee.**

Instructions for Completing Section B:

- If services were provided, state the date, start time, end time and the name of the interpreter. If services were cancelled, state the date and time the service request was cancelled.
- Obtain Manager/designee signature to verify information in Section B is accurate.
- **FAX the Service Authorization Form with Section B completed to the selected provider after the services have either been completed or cancelled.**

It is an expectation that all programs will make every effort to develop bilingual/bicultural staff to reflect the population they serve. In this way, services will be delivered in a culturally competent manner, in the client's preferred language; and interpreter services will be utilized more efficiently by everyone.

County of San Diego
Health and Human Services Agency (HHSA)

SERVICE AUTHORIZATION FORM
Interpreter Services for Clients – Access and Authorization
This form to be completed for one person and one date only

Instructions:

1. Complete Section A to request interpreter services and fax to interpreter service provider selected.
   If requesting for multiple appointments, list each appointment time separately.
2. Complete Section B following services provided or cancelled and fax to interpreter service provider.
3. Retain original form at program site for record of services requested.

Please "X" the provider selected:

	Service Provider	Phone	Fax	Type of Interpreting
___	Interpreter's Unlimited	(800) 726-9891	(800) 726-9822	Oral Interpreter Services
___	Deaf Community Services	(619) 398-2488	(619) 398-2490	American Sign Language
___	Network Interpreting Services	(800) 284-1043	(815) 425-9244	ASL Back up

Section A

The County of San Diego, HHSA has authorized the following interpreting services for client / family member
(circle one)

_____ on _____. (If under 18, age of child _____).
(Name) (month/day/year)

Type of Appointment:	Language Requested:	Begin Time:	End Time:	Requested By:

Agency Name: _____
Program Name: _____
Program Address: _____
Service Site (if different from program address) _____
County department to be invoiced: _____
If requesting for a Mental Health Program, please check one: Children's MH___Adult/OlderAMH___

Approved By: _____
(Signature of Manager/designee) (Date)
Print Name: _____
Phone: ( ) _____ Fax: ( ) _____

Section B

The above service was provided on _____from _____ to _____ by _____.
(Date) (Start Time) (End Time) (Name of Interpreter)

OR:

The above service was cancelled on: _____
(Date) (Time)

Interpreter Services Were Provided OR Cancelled As Stated Above:

Verified by: _____
(Manager/designee) (Date)

NOTE: IT IS A HIPAA VIOLATION TO EMAIL ANY DOCUMENT CONTAINING PROTECTED HEALTH INFORMATION (PHI).

(Rev.12.3.2007 mbeamon)

Appendix D
Providing Specialty Mental Health Services

SAN DIEGO COUNTY MENTAL HEALTH PLAN
72 – HOUR POST DISCHARGE LOG FOR SPECIALTY MENTAL HEALTH SERVICES

CARE COORDINATOR: _____ **MONTH/YEAR:** _____

Client Name	InSyst #	Admission Facility & Date of Admission	Date Program Learned of Admission	Date of Discharge	Date of Follow-up Appt.	Client Showed (yes or no)

A.D.2

Rev. 07-05

Medical Necessity Criteria for MHP Reimbursement of Specialty Mental Health (Title IX 1830.205)

(a) The following medical necessity criteria determines Medi-Cal reimbursement for specialty mental health services that are the responsibility of the MHP under this subchapter, except as specifically provided.

(b) The beneficiary must meet criteria outlined in (1), (2), and (3) below to be eligible for services:

(1) Be diagnosed by the MHP with one of the following diagnoses in the Diagnostic and Statistical Manual, Fourth Edition, published by the American Psychiatric Association:

(A) Pervasive Developmental Disorders, except Autistic Disorders

(B) Disruptive Behavior and Attention Deficit Disorders

(C) Feeding and Eating Disorders of Infancy and Early Childhood

(D) Elimination Disorders

(E) Other Disorders of Infancy, Childhood, or Adolescence

(F) Schizophrenia and Other Psychotic Disorders

(G) Mood Disorders

(H) Anxiety Disorders

(I) Somatoform Disorders

(J) Factitious Disorders

(K) Dissociative Disorders

(L) Paraphilias

(M) Gender Identity Disorder

(N) Eating Disorder

(O) Impulse Control Disorders not Elsewhere Classified

(P) Adjustment Disorders

(Q) Personality Disorders, excluding Antisocial Personality Disorder

(R) Medication-induced Movement Disorders related to other included diagnoses

(2) Must have at least one of the following impairments as a result of the mental disorder(s) listed in subdivision (1) above:

(A) A significant impairment in an important area of life functioning.

(B) A probability of significant deterioration in an important area of life functioning.

(C) Except as provided in Section 1830.210, a probability a child will not progress developmentally as individually appropriate. For the purpose of this section, a child is a person under the age of 21 years.

(3) Must meet each of the intervention criteria listed below:

(A) The focus of the proposed intervention is to address the condition identified in (2) above.

(B) The expectation is that the proposed intervention will:

1. Significantly diminish the impairment, or

2. Prevent significant deterioration in an important area of life function, or

3. Except as provided in Section 1830.210, allow the child to progress developmentally as individually appropriate.

(C) The condition would not be responsive to physical health care based treatment.

(c) When the requirements of this section are met, beneficiaries shall receive specialty mental health services for a diagnosis included in subsection (b)(1) even if a diagnosis that is not included in subsection (b)(1) is also present.

California State Penal Institutions

Avenal State Prison

California Correctional Center

California Correctional Institution

California Institution for Men

California Institution for Women

California Medical Facility

California Men's Colony

California Rehabilitation Center

California State Prison, Corcoran

California State Prison, Los Angeles County

California State Prison, Sacramento

California State Prison, Solano

Calipatria State Prison

Centinela State Prison

California Substance Abuse Treatment Facility

Central California Women's Facility

Chuckawalla Valley State Prison

Correctional Training Facility

Deuel Vocational Institution

Folsom State Prison

High Desert State Prison

Ironwood State Prison

Mule Creek State Prison

North Kern State Prison

Northern California Women's Facility

Pelican Bay State Prison

Pleasant Valley State Prison

Richard J. Donovan Correctional Facility at Rock Mountain

Salinas Valley State Prison

San Quentin State Prison

Sierra Conservation Center

Valley State Prison for Women

Wasco State Prison

START PROGRAM TCC & URC RECORD

Facility Name: _____ TCC/URC Date: _____
Client Name: _____ Admit Date: _____

Client attended this meeting? YES ☐ NO ☐ If no, explain:_____
Input from client (regarding treatment requests, suggestions or preference):_____
_____
_____

Progress and status of presenting symptoms (per client report & staff observations):_____
_____
_____

Response to Medications (per client report & staff observation):_____
_____

Input from Other Mental Health Providers (if applicable):_____
_____

Treatment Recommendations (effective interventions, treatment approach, focus of treatment, housing, follow-up treatment, medications...):_____
_____
_____
_____
_____

Change in Diagnostic Impression: ☐ No Change from Dx at Admission ☐ Change Noted Below
Axis I_____
Axis I_____
Axis II_____
Justification:_____
_____

D/C Plans: **D/C Date:** _____ Is client at risk for readmission? No ☐ Yes ☐
Housing: _____ Finances: _____
Med Monitoring: _____ Tx: _____
Other: _____

Signatures of staff attendees:_____
_____

DATE OF NEXT REVIEW: ☐

REVIEW DATE: _____

Note Progress (sxs, med. changes, response to meds., extension needed...)_____
_____
_____

Signatures of staff attendees: _____
_____

Policy #_____
Effective date:_____

URC Minutes

Program Name:_____ Date:_____ Meeting Time:_____

Chairperson Name, Signature and Credentials:_____

Signatures of Committee Members (include credentials):_____
_____
_____

Client Name	Admit Date	Dates Authorized Through	Tentative D/C Date	Comments

NOTE: Requests for extensions and result will be noted in the “Comments” column

REQUEST FOR UTILIZATION REVIEW OUTPATIENT SERVICES

Admission Date:_____ Date of Last Review:_____

Current Axis I – Primary:_____

Secondary:_____

Other:_____

Axis II – _____

Axis III – _____

Axis IV – ☐ Primary Support Group ☐ Social Environment ☐ Educational
☐ Occupational ☐ Housing ☐ Economic
☐ Access to Health Care ☐ Interaction with Legal System
☐ Other Psychosocial/Environmental Problems

Axis V – (GAF) Current _____Highest in Last 12 Months _____

Complete Functional Impairments and Current Symptoms sections based on client's presentation over prior 30-day period.

Current Functional Impairments:	N/A	Mild	Moderate	Severe
Family	☐	☐	☐	☐
Relationship with Spouse/Partner	☐	☐	☐	☐
Other Primary Relationships	☐	☐	☐	☐
Health/Physical Well-Being/ADL's	☐	☐	☐	☐
Work/School	☐	☐	☐	☐
Housing	☐	☐	☐	☐
Finances	☐	☐	☐	☐
Other:_____	☐	☐	☐	☐

Current Symptoms:	N/A	Mild	Moderate	Severe
Suicidal Ideation	☐	☐	☐	☐
Homicidal Ideation/Impulses	☐	☐	☐	☐
Self-Harm Behavior	☐	☐	☐	☐
Violence/Anti-Social Behavior	☐	☐	☐	☐
Poor Impulse Control	☐	☐	☐	☐
Paranoia	☐	☐	☐	☐
Bizarre Behavior	☐	☐	☐	☐
Bizarre Ideation/Delusions	☐	☐	☐	☐
Auditory Hallucinations	☐	☐	☐	☐
Visual Hallucinations	☐	☐	☐	☐
Mood Disturbance	☐	☐	☐	☐
Appetite Disturbance	☐	☐	☐	☐
Sleep Disturbance	☐	☐	☐	☐
Hopelessness/Helplessness	☐	☐	☐	☐
Fatigue/Lethargy	☐	☐	☐	☐
Somatic Complaints	☐	☐	☐	☐
Anxiety/Panic	☐	☐	☐	☐
Obsessions/Compulsions	☐	☐	☐	☐
Other:_____	☐	☐	☐	☐

Client:_____

MR/Client ID#:_____

Program:_____

REQUEST FOR UTILIZATION REVIEW OUTPATIENT SERVICES

Psychiatric hospitalizations or START admissions within past 12 months: ☐ Yes ☐ No

If yes, specify date(s) and duration(s):

_____

_____

Current Medications: _____

_____

_____

Have there been any medication changes within past 6 months: ☐ Yes ☐ No

Current Treatment Modalities: ☐ Individual Therapy ☐ Group Therapy ☐ Case Management ☐ Rehabilitation

Current Participation: ☐ Regular Attendance ☐ Occasionally Missed Sessions ☐ Frequently Missed Sessions

Progress Update: ☐ Progressing and Improvement ☐ Some Progress, Remains at Risk ☐ Minimal Progress or Improvement ☐ Not Progressing

Proposed Treatment Modalities: ☐ Individual Therapy ☐ Group Therapy ☐ Case Management ☐ Rehabilitation

Additional Comments: _____

_____

_____

Requested # of months continued treatment (not to exceed 6 months) _____

Clinician's Signature _____ **Date** _____

Printed Name: _____

This section to be completed by UR Clinician at time of review.

Client's continued treatment is authorized for____months (not to exceed 6 months)

Comments: _____

_____

_____

_____

Authorization Period: Begin Date_____ **End Date**_____

UR Clinician Signature:_____ Date_____

Printed Name:_____

County of San Diego
Health and Human Services Agency
Adult Mental Health

04/01/05

Client: _____

MR/Client ID#: _____

Program: _____

Outpatient Utilization Review Minutes

Program Name:_____ **Date:**_____

Committee Members, Credentials: **Signatures:**

Chairperson, Credentials: **Signature:**

Client Name	InSyst#	Disposition		
		☐ Request Approved	☐ Request Reduced	☐ Request Denied
		☐ Request Approved	☐ Request Reduced	☐ Request Denied
		☐ Request Approved	☐ Request Reduced	☐ Request Denied
		☐ Request Approved	☐ Request Reduced	☐ Request Denied
		☐ Request Approved	☐ Request Reduced	☐ Request Denied
		☐ Request Approved	☐ Request Reduced	☐ Request Denied
		☐ Request Approved	☐ Request Reduced	☐ Request Denied
		☐ Request Approved	☐ Request Reduced	☐ Request Denied

Outpatient Utilization Review Minutes
(continued)
Page ___ of ___

Program Name:____ **Date:**________________________________

Client Name	InSyst#	Disposition		
		☐ Request Approved	☐ Request Reduced	☐ Request Denied
		☐ Request Approved	☐ Request Reduced	☐ Request Denied
		☐ Request Approved	☐ Request Reduced	☐ Request Denied
		☐ Request Approved	☐ Request Reduced	☐ Request Denied
		☐ Request Approved	☐ Request Reduced	☐ Request Denied
		☐ Request Approved	☐ Request Reduced	☐ Request Denied
		☐ Request Approved	☐ Request Reduced	☐ Request Denied
		☐ Request Approved	☐ Request Reduced	☐ Request Denied
		☐ Request Approved	☐ Request Reduced	☐ Request Denied
		☐ Request Approved	☐ Request Reduced	☐ Request Denied
		☐ Request Approved	☐ Request Reduced	☐ Request Denied
		☐ Request Approved	☐ Request Reduced	☐ Request Denied

Case Management URC Record

Program Name: _____ URC Date: _____

Client Name: _____ Admission Date: _____

Client S#: _____

Primary Diagnostic Impression and Justification on Date of UR:

Axis I or Axis II:

Chart documents Medical Necessity:

_____ Yes _____ No

Comments:

Chart documents Service Necessity:

_____ Yes _____ No

Comments:

Recommended Level of Case Management Services:

Discharge Plan/Other Service Recommendations:

_____ _____

Name of person reviewing chart Signature

URC Minutes for Case Management

Program Name: **Date of URC:**

Committee Members

Print Name	Signature	Degree/License
Chair:		

List of Charts Reviewed

Client Name	Admit Date	Date Authorized Through	Continue at Same LOS	Transfer to Preventive LOS	Transfer to Comprehensive LOS	Discharge from Program	Comments
			Y N	Y N	Y N	Y N	
			Y N	Y N	Y N	Y N	
			Y N	Y N	Y N	Y N	
			Y N	Y N	Y N	Y N	
			Y N	Y N	Y N	Y N	
			Y N	Y N	Y N	Y N	
			Y N	Y N	Y N	Y N	
			Y N	Y N	Y N	Y N	
			Y N	Y N	Y N	Y N	

Current Level of Case Management Services:

_____ Preventive (Maintenance)
_____ Comprehensive (Traditional)
_____ Intensive
_____ Older Adult

Location of Service	
Duration of Service	
Service Code	

_____ Assessment Reviewed _____ No changes _____Changes noted/initialed

_____ Medical History Reviewed _____ No changes _____Changes noted/initialed

_____ CFE Completed or Reviewed _____ No changes _____Changes noted/initialed

_____Client meets Medical Necessity for Mental Health Plan Specialty Mental Health Services by:

Current Diagnosis: Axis I _____ # _____. ____

Axis II _____ # _____. ____

AND:

_____ Client has a significant impairment in life functioning. **OR:**

_____ Client has a probability of significant deterioration in an important area of functioning

Describe:

AND all three of the following are true:

_____ The focus of the mental health intervention will address the condition described above

_____ It is expected that the client will benefit from interventions listed on the revised or new Client Plan, which has been signed (_____client refused to sign)

_____ The client's impairment would not be responsive to physical healthcare based treatment

AND:

_____ The client meets Service Level of Care Criteria for Case Management Services (Over)

_____ _____ _____
Clinician Name Signature Date

The case manager's signature verifies that client meets both Medical Necessity and Service Level of Care Criteria

SERVICE LEVEL OF CARE CRITERIA (Must Meet Either A or B)

A. FOR CONTINUING COMPREHENSIVE (TRADITIONAL) CASE MANAGEMENT SERVICES

Treatment history meets ONE of the following criteria

_____ 10 days or 2 admissions for psychiatric inpatient treatment in the past twelve months

_____ 28 days or 4 admissions to a crisis house in the past twelve months.

_____ Discharge from an IMD in the past twelve months

_____ LPS Conservatorship is in effect - Client is gravely disabled as a result of a mental disorder.

OR: TWO of the following are true regarding client's functioning

_____ Client is a young adult (18 – 21) transitioning from the Children's System of Care.

_____ Client is 55 or older and mental illness is exacerbated due to issues of aging or loss of support.

_____ Client has at least (3) missed mental health appointments, or documentation that medication has not been taken on at least five occasions during the past twelve months, or has had two or more face -to-face encounters with crisis intervention/emergency services personnel; within the past twelve months

_____ Besides mental health needs, client requires assistance with two or more human service agencies or public systems such as Drug and Alcohol, Vocational Rehabilitation, Criminal Justice, Physical Health Care, and Public Benefits. List the agencies:

_____ _____

_____ Due to high risk behaviors, client has had one period of homelessness or one or more disruptions to placement or place of treatment in the past two years. List the disruptions

_____ _____

B. FOR CONTINUING CASE MANAGEMENT AT A PREVENTIVE (MAINTENANCE) LEVEL

BOTH of the following are true

1._____ Client requires ongoing support and assistance from case management to attend psychiatric treatment appointments or obtain and take medications.

2._____ Despite ongoing attempts by case manager to allow client to manage own funds and complete necessary paperwork to keep benefits in place, over the past twelve months, client has not been able to do so without assistance and there are no other persons available to provide the assistance.

Additional comments:

Appendix E
Interface With Physical Health Care

HEALTHY SAN DIEGO
COORDINATION OF CARE FORM GUIDELINES
FOR PHYSICAL AND BEHAVIORAL HEALTH PRACTITIONERS

The purpose of the Healthy San Diego (HSD) Coordination of Care form is to provide a communication tool for use between physical and specialty mental health practitioners. Either side of the care continuum may initiate communication by completing the form, obtaining the client's written consent and forwarding the information to the appropriate practitioner. The use of the Coordination of Care form allows for exchange of essential medical information such as diagnosis and medications. By enhancing the communication between practitioners, HSD's goal of improved health outcomes can be achieved.

Primary Care Provider Responsibilities

The Primary Care Provider (PCP) is the primary case manager for the Health Plan member, and as such, makes referrals to specialists, as needed. The PCP is responsible for providing outpatient mental health services within his/her scope of practice. When the member requires Specialty Mental Health Services, the PCP will refer him/her to the Mental Health Plan for appropriate referral, assessment and treatment. The member may also self-refer to the Mental Health Plan's Access and Crisis Line.

- The PCP refers to Specialty Mental Health Services on the basis of objective and subjective evaluation of the member's medical history, psychosocial history, current state of health and any request for such services from either the member or the member's family.
- The PCP will inform the Specialty Mental Health Provider of any physical health conditions or medications which may influence possible mental health conditions.
- The PCP documents the mental health condition in the member's medical record.
- The PCP makes available to the Specialty Mental Health Provider any medical records and documentation relating to the member's mental health condition only if the client signs the Authorization to Release according to Health Plan policy and applicable laws and regulations.

Specialty Mental Health Provider Responsibilities

When a client requires physical health services, the Specialty Mental Health Provider will advise him/her to make an appointment with the PCP or contact the Health Plan's Member Services Department for assistance.

The Specialty Mental Health Provider may make available to the PCP the client's medical information relating to the diagnosis and plan of treatment only if the client signs the Authorization to Release, which allows specific medical information to be given to the PCP. The Specialty Mental Health Provider will inform the Primary Care Provider of any mental health conditions or medications which may influence possible physical health conditions. Mental health information will be shared according to the County Mental Health Plan policy and applicable laws and regulations.

Member/Client Responsibilities

Members/clients can access Specialty Mental Health Services through referrals from their PCP, family members or medical specialists. Clients also may access services directly by calling the County of San Diego Mental Health Plan Access and Crisis Line's toll free number (800) 479-9339 or by contacting a Specialty Mental Health Provider.

HSD's Coordination of Care form is available at *www.ubhpublicsector.com*

To Reach a Representative

Blue Cross Of California	(800) 407-4627	Health Net	(800) 675-6110	Universal Care	(800) 635-6668
Community Health Group	(800) 404-3332	Kaiser Permanente	(800) 464-4000	Access and Crisis Line	(800) 479-3339
		Sharp Health Plan	(800) 359-2002		

COORDINATION OF CARE

BETWEEN PHYSICAL & BEHAVIORAL HEALTH PRACTITIONERS

SECTION A. CLIENT INFORMATION				
Name Last	First	Middle Initial	AKA	☐ Male ☐ Female
Street Address			Date of Birth	
City			Telephone #	
Zip			Alternate Telephone #	

SECTION B. BEHAVIORAL HEALTH PRACTITIONER INFORMATION		
Name		
Organization OR Medical Group		
Street Address	City, State, Zip	
Telephone #	Fax #	
Date of Initial Assessment	Diagnosis	Diagnosis
Current Symptoms		
Current Medications		
Summary of Patient Evaluation	Current Treatment Plan	

SECTION C. PHYSICAL HEALTH PRACTITIONER INFORMATION		
Name		
Organization OR Medical Group		
Street Address	City, State, Zip	
Telephone #	Fax #	
Date of Initial Assessment	Diagnosis	Diagnosis
Current Symptoms		
Current Medications		
Summary of Patient Evaluation	Current Treatment Plan	

To Reach a Plan Representative

Blue Cross Of California	(800) 407-4627	Health Net	(800) 675-6110	Universal Care	(800) 635-6668
Community Health Group	(800) 404-3332	Kaiser Permanente	(800) 464-4000	United Behavioral Health	(800) 479-3339
		Sharp Health Plan	(800) 359-2002		

Sensitive Information: I understand that the information in my record may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or infection with the Human Immunodeficiency Virus (HIV). It may also include information about behavioral or mental health services or treatment for alcohol and drug abuse.

Right to Revoke: I understand that I have the right to revoke this authorization at any time. I understand if I revoke this authorization I must do so in writing. I understand that the revocation will not apply to information that has already been released based on this authorization.

Photocopy or Fax:
I agree that a photocopy or fax of this authorization is to be considered as effective as the original.

Redisclosure: If I have authorized the disclosure of my health information to someone who is not legally required to keep it confidential, I understand it may be redisclosed and no longer protected. California law generally prohibits recipients of my health information from redisclosing such information except with my written authorization or as specifically required or permitted by law.

Other Rights: I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I do not need to sign this form to assure treatment. However, if this authorization is needed for participation in a research study, my enrollment in the research study may be denied. I understand that I may inspect or obtain a copy of the information to be used or disclosed, as provided in 45 Code of Federal Regulations section164.524.

SECTION D SIGNATURE OF INDIVIDUAL OR LEGAL REPRESENTATIVE

SIGNATURE:	DATE:

IF SIGNED BY LEGAL REPRESENTATIVE, RELATIONSHIP OF INDIVIDUAL:

Expiration: Unless otherwise revoked, this authorization will expire on the following date, event, or condition: _____If I do not specify an expiration date, event or condition, this authorization will expire in one (1) calendar year from the date it was signed, or 60 days after termination of treatment.

FOR OFFICE USE	ID VALIDATION
SIGNATURE OF STAFF PERSON VALIDATING IDENTIFICATION:	DATE:
SIGNATURE OF HEALTH CARE PROVIDER:	DATE:

The above signed authorizes the behavioral health practitioner and the physical health practitioner to release the following medical records and information concerning the patient. The purpose of such a release is to allow for coordination of care, which enhances quality and reduces the risk of duplication of tests and medication interactions. Refusal to provide consent could impair effective coordination of care.

o Information Contained on this form o Current Medication & Treatment Plan o Substance Dependence Assessments o Assessment /Evaluation Report	o Discharge Reports/Summaries o Laboratory/Diagnostics Test Results o Medical History o Other _____

To Reach A Health Plan Representative Call:

Blue Cross Of California	(800) 407-4627
Community Health Group	(800) 404-3332
Health Net	(800) 675-6110
Kaiser Permanente	(800) 464-4000
Sharp Health Plan	(800) 359-2002
Universal Care	(800) 635-6668
United Behavioral Health	(800) 479-3339

Client Name { *Please type or print clearly*}

(Last) _____

(First) _____

I would like a copy of this authorization.

☐ Yes ☐ No Initials ☐

PLACE A COPY OF THIS FORM IN THE CLIENT'S MEDICAL RECORD

Appendix F
Beneficiary Rights & Issue Resolution

BENEFICIARY AND CLIENT PROBLEM RESOLUTION POLICY AND PROCESS

I. BENEFICIARY AND CLIENT PROBLEM RESOLUTION POLICY

In its commitment to honoring mental health consumer rights, the County of San Diego shall maintain a beneficiary and client problem resolution process, in compliance with State and Federal regulations, which provides a quality, impartial, and effective process for resolving consumer problems encountered while accessing or receiving mental health services. All County-operated and contracted providers shall be required by contract to cooperate with the problem resolution process as described herein. The full and timely cooperation of the provider shall be considered essential in honoring the client's right to an efficient problem resolution.

A. PROCESS

San Diego County Mental Health Services is committed to providing a quality, impartial, and effective process for resolving consumer complaints encountered while accessing or receiving mental health services. The process is designed to:

- Provide easy access
- Support the rights of individuals
- Be action-oriented
- Provide timely resolution
- Provide effective resolution at the lowest level
- Improve the quality of services for all consumers in the population

While the consumer is encouraged to present problems directly to the provider for resolution, when a satisfactory resolution cannot be achieved, one or more of the processes below may be used:

1) Grievance process
2) Appeal process (in response to an "action" as defined as: denying or limiting authorization of a requested service, including the type or level or service; reducing, suspending, or terminating a previously authorized service, denying, in whole or in part, payment for a service; failing to provide services in a timely manner, as determined by the Mental Health Plan (MHP) or; failing to act within the timeframes for disposition of standard grievances, the resolution of standard appeals or the resolution of expedited appeals.)
3) Expedited Appeal process (available in certain limited circumstances)
4) State Fair Hearing process--available to Medi-Cal beneficiaries who have filed an appeal through the County Mental Health Program (MHP) process and are dissatisfied with the resolution. The State Fair Hearing is also for clients whose grievance or appeal was not resolved timely in the MHP process (including an extension if permission was given), or no permission for an extension was given. In this instance, clients are not required to wait until the completion of the County MHP process to do so.

The Mental Health Problem Resolution process covers Medi-Cal beneficiaries, Severely Emotionally Disabled (SED) certified children through the Healthy Families program, and persons without Medi-Cal funds receiving County-funded mental health services. It is designed to meet the regulations in CCR Title 9, Division 1, Chapter 11, Subchapter 5,

Section 1850.205 and 42 CFR Subpart F, Part 438.400. **The procedures relating to children and youth served under AB 3632/2726 legislation will take precedence over this document.** By law, Welfare and Institution (WI) Code WI 10950, the State Fair Hearing process, is only available to a Medi-Cal beneficiary.

B. OBJECTIVES

1. To provide the consumer with a process for independent resolution of grievances and appeals.

2. To protect the rights of consumers receiving mental health services, including the right to:

- Be treated with dignity and respect,
- Be treated with due consideration for his or her privacy,
- Receive information on available treatment options in a manner appropriate to his or her condition and ability to understand,
- Participate in decisions regarding his or her mental health care, including the right to refuse treatment,
- Be free from any form of unnecessary restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation,
- Request a copy of his or her medical records, and to request that an additional statement amending or correcting the information be included, and
- Freely exercise these rights without adverse effects in the way providers treat him or her.

3. To protect the rights of consumers during grievance and appeal processes.

4. To assist individuals in accessing medically necessary, high quality, consumer-centered mental health services and education.

5. To respond to consumer concerns in a linguistically appropriate, culturally competent and timely manner.

6. To provide education regarding, and easy access to, the grievance and appeal process through widely available informational brochures, posters, and self-addressed grievance and appeal forms located at all provider sites.

C. BENEFICIARY and CLIENT RIGHTS DURING THE GRIEVANCE AND APPEAL PROCESS

1. Consumer concerns shall be responded to in a linguistically appropriate, culturally competent and timely manner.

2. Clients' rights and confidentiality shall be protected at all stages of the grievance and appeal process by all providers and advocates involved.

3. Consumers shall be informed of their right to contact the University of San Diego (USD) Patient Advocacy Program regarding problems at inpatient and residential mental health facilities or the Consumer Center for Health Education and Advocacy (CCHEA) for problems with outpatient and all other mental health services, at any time for assistance in resolving a grievance or appeal. Medi-Cal beneficiaries shall also be informed of their right to request a State Fair Hearing.

4. Consumers of the MHP and persons seeking services shall be informed of the process for resolution of grievances and appeals. This includes information about the availability of the USD Patient Advocacy Program and CCHEA, the programs that currently are contracted with the MHP to assist consumers with problem resolution, at the consumer's request. The information shall be available in the threshold languages, and shall be given to the client at the point of intake to Mental Health Plan services, and upon request during the provision of services. Continuing clients must be provided with the information annually. Providers shall document the provision of this information.

5. The client may authorize another person or persons to act on his/her behalf. A client may select a provider as his or her representative in the appeal process. His or her representative, or the legal representative of a deceased client's estate, shall be allowed to be included as parties to an appeal.

6. A support person chosen by the client, such as family member, friend or other advocate may accompany them to any meetings or hearings regarding a grievance or appeal.

7. The client and/or his or her representative may examine the case file, including documents or records considered during the grievance or appeal process.

8. Consumers shall not be subject to any discrimination, penalty, sanction or restriction for filing a grievance or appeal. The consumer shall not be discouraged, hindered or otherwise interfered with in seeking or attempting to file a grievance or appeal.

9. Advocates shall treat clients, their chosen support persons, and all providers with courtesy and respect throughout the grievance resolution process.

- Providers shall participate fully and in a timely manner in order to honor the client's right to an efficient, effective problem resolution process.
- Medi-Cal beneficiaries, who have appealed through the MHP Beneficiary Problem Resolution process and are dissatisfied with the resolution, have the right to request an impartial review in the form of a State Fair Hearing within 90 days of the decision whether or not the client received a Notice of Action (NOA). At a State Fair Hearing, a client has the opportunity to present his or her concerns to an administrative law judge for a ruling. (See Section VIII for more information on the State Fair Hearings.)
- Clients who are Medi-Cal beneficiaries and who have a grievance or appeal which has not been resolved by the MHP within mandated timelines, and no client permission for an extension has been granted, may request a State Fair Hearing. They need not wait until the end of the County process before making the request.
- Quality of care issues identified as a result of the grievance and appeal process shall be reviewed by the MHP and the Quality Review Council for implementation of system changes, as appropriate.

D. CLIENT AND BENEFICIARY NOTIFICATION

1. Consumers shall be informed in a clear and concise way of the process for reporting and resolving grievances and appeals. This includes information on how to contact USD Patient Advocacy and CCHEA. The information shall be available in the threshold languages and shall be given to the client at the point of intake to a program and, as appropriate, during the provision of services. Continuing clients must be provided with the information annually, and providers will document these efforts.
2. Notices in threshold languages describing mental health rights, as well as the grievance and appeal procedures, shall be posted in prominent locations in public and staff areas, including waiting areas of the provider location. Brochures with this information will also be available in these areas in the County's threshold languages.
3. Grievance/Appeal forms and self-addressed envelopes must be available for consumers at all provider sites in a visible location, without the consumer having to make a written or verbal request to anyone. This includes common areas of both locked and unlocked behavioral health units.
4. CCHEA and Patient Advocacy Program shall have interpreter services and toll-free numbers with adequate TDD/TTY, available at a minimum during normal business hours.
5. Under certain circumstances, when the MHP denies any authorization for payment request from a provider to continue specialty mental health services to a Medi-Cal beneficiary, the MHP must provide the Medi-Cal beneficiary with a Notice of Action (NOA), which informs the beneficiary of his or her right to request a State Fair Hearing, and the right to contact a representative from USD or CCHEA.

II. INFORMAL PROBLEM RESOLUTION –available to all mental health clients

Consumers are encouraged to seek problem resolution at the provider level by speaking or writing informally to the therapist, case manager, facility staff, or other person involved in their care. Often this is the quickest way to both make the provider aware of the client's issue, as well as come to a satisfactory resolution. **However, no consumer shall be required to take the matter directly to the provider unless he or she chooses.**

In addition to, or instead of, bringing the issue directly to the individual provider, consumers may work directly with the supervisor or Program Director, who shall make efforts to resolve it. In attempting to reach resolution, and consistent with confidentiality requirements, the appropriate supervisor or Program Director shall utilize whatever information, resources and/or contacts the consumer agrees to.

III. GRIEVANCE PROCESS—available to all mental health clients

Any consumer of mental health services may express dissatisfaction with mental health services or their administration by filing a grievance through USD Patient Advocacy (for inpatient and residential services) or the Consumer Center for Health Education and

Advocacy (for outpatient and all other mental health services.)

IV. GRIEVANCE PROCEDURES:

At any time the consumer chooses, the consumer may contact CCHEA or USD Patient Advocacy, as appropriate. CCHEA or USD Patient Advocacy shall work to resolve the issue according to the following steps:

1. Client contacts USD Patient Advocacy Program for issues relating to inpatient and other 24-hour-care programs, or CCHEA for issues relating to outpatient, day treatment and all other services, either orally or in writing, to file a grievance. A grievance is defined as an expression of dissatisfaction about anything other than an "action" (see Section IV for complete definition.).
   NOTE: If the client's concern is in regard to an "action" as defined, the issue is considered an "appeal" (see Section X for Definition). not a grievance. See "Appeal Process" in Section V below for procedure.

2. CCHEA or Patient Advocacy Program logs the grievance within one working day of receipt. The log shall include:

   - the client name or other identifier,
   - date the grievance was received,
   - the date it was logged, the nature of the grievance,
   - the provider name,
   - whether the issue concerns a child.

   The log is to be maintained in a confidential location at CCHEA or USD Patient Advocacy. The log content pertaining to the client shall be summarized in writing, if the client requests it.

3. CCHEA or Patient Advocacy Program provides the client a written acknowledgement of receipt of the grievance within three working days.

4. CCHEA or Patient Advocacy Program shall contact the provider involved in the grievance as soon as possible and within three working days of receipt of the client's written permission to represent the client.

5. CCHEA or Patient Advocacy Program investigates the grievance.

   - CCHEA or USD shall ensure that the person who makes the final determination of the grievance resolution has had no prior or current involvement in the grievance determination.
   - In cases where the CCHEA or USD staff member has another existing relationship with the client or provider, that contractor's Program Director shall reassign the case or consult with the MHP QI Unit about conflict of interest of issues.
   - The client's confidentiality shall be safeguarded per all applicable laws.

6. If the grievance is about a clinical issue, the decision maker must be a mental health professional with the appropriate clinical expertise in treating the client's

condition.

7. All County-operated programs and contracted providers are required by contract to cooperate with the problem resolution process as it is described herein. The full participation and timely cooperation of the provider are essential to honoring the client's right to an efficient, effective problem resolution process. During the resolution of the client's grievance, CCHEA or Patient Advocacy staff will often find it necessary to discuss the issue with the providers involved, either in person or by phone at various points in the process. The expectation is that CCHEA or USD and the provider will cooperate with each other to find mutually agreeable and expeditious ways to address and resolve the client's issue.

   If a case should arise in which CCHEA or USD and the provider are unable to reach a mutually agreeable resolution to the grievance within the required timeframe as stated below, CCHEA or USD shall make a finding based on the facts as they are known. The grievance disposition letter shall include this finding. The letter may include a request that the provider write a Plan of Correction to be submitted by the provider directly to the MHP Director or designee. CCHEA or USD may also choose to include what they believe to be equitable, enforceable suggestions or recommendations to the provider for resolution of the matter. Notification of the resolution shall go out to all parties as described below.

8. CCHEA or Patient Advocacy Program shall notify the client in writing regarding the disposition of the grievance within the timeframe for resolution stated below. The notice shall include:
   - the date
   - the resolution

   A copy of the grievance resolution letter will be sent to the provider and the QI Unit at the time the letter is sent to the client.

9. Timelines for grievance dispositions cannot exceed 60 calendar days from the date of receipt of the grievance. However, in some limited instances, it may be necessary for the timeframe to be extended by up to 14 calendar days for good cause, such as a satisfactory resolution is pending but not complete. Timeliness of grievance resolution is an important issue for consumers. If an extension is required, CCHEA or USD will contact the client to discuss an extension, clearly document in the file the extenuating circumstances that indicate the need for the extension, and the date the client was contacted and agreed to an extension. If the timeframe extension was not requested by the client, CCHEA or USD staff must give the client written notice of the reason for the delay. If CCHEA or USD staff is unable to meet the timeframe described herein, the staff person shall issue a Notice of Action D (NOA-D) to the beneficiary informing them of their rights. A copy of the NOA-D shall be sent to the QI Unit. Clients whose grievances are not completed according to mandated timelines, and have not given permission for an extension, may request a State Fair Hearing. They need not wait until the end of the County process to make this request.

10. CCHEA or USD Patient Advocacy Program shall record in the log, the final disposition of the grievance, and date the decision was sent to the client, or reason

there has not been a final disposition of the grievance.

11. Providers who do not successfully resolve the grievance with the advocacy organization during the grievance process shall receive two letters from CCHEA or USD. One is a copy of the disposition sent to the client, that includes a request for Plan of Correction, and the other is a letter requesting that the provider write a Plan of Correction and submit it within 10 working days directly to:

Grievance Plan of Correction
Quality Improvement Unit
P.O. Box 85524, Mail Stop P531G
Camino Del Rio South
San Diego, CA 92186-5524

The Plan of Correction letter to the provider (not the grievance disposition letter) may include CCHEA's or USD's suggestions of what the Plan of Correction could include. Responsibility for reviewing the Plan of Correction and monitoring its implementation rests with the MHP. The monitoring of any provider's Plan of Correction and handling of any provider's request for administrative review shall be performed by the MHP directly with the provider.

In the event that a provider disagrees with the findings of the grievance investigation as decided by the advocacy organization, and does not agree to write a Plan of Correction, the provider may choose instead to write a request for administrative review by the MHP. This request shall be submitted directly by the provider to the MHP Director or designee within 10 working days of receipt of the grievance disposition. The provider must include rationale and evidence to support the provider's position that the disposition of the grievance is faulty and/or that no Plan of Correction is indicated.

Reminder: Providers shall not subject a client to any discrimination or any other penalty of any kind for filing a grievance.

GRIEVANCE PROCESS

STEP	ACTION	TIMELINE
1	Grievance Filed by client	Filing Date
2	Grievance Logged	1 Working Day from Grievance Filing
3	Written Acknowledgement to client	3 Working Days from Grievance Filing
4	Provider Contact	Within 3 Working Days from Client's Written Permission to Represent
5	Clinical Consultant review, if applicable	Within 60 day total timeframe
6	Grievance Disposition	60 Days from Filing Date
7	Disposition Extension (if needed)	14 Calendar Days from the 60th day
8	Provider Plan of Correction (if needed)	10 Working Days from Disposition Date
9	Request for Administrative Review	10 Working Days from receipt of the Grievance Disposition

V. APPEAL PROCESS—available to Medi-Cal Beneficiaries only

The appeal procedure begins when a Medi-Cal beneficiary contacts USD Patient Advocacy Program (for issues relating to inpatient and other 24 hour care program) or CCHEA (for issues relating to outpatient, day treatment and all other services) to file an appeal to review an "action."

An "action" is defined by 42 Code of Federal Regulations as occurring when the MHP does at least one of the following:

- Denies or limits authorization of a requested service, including the type or level of service;
- Reduces, suspends, or terminates a previously authorized service;
- Denies, in whole or in part, payment for a service;
- Delays completion of the MHP appeals process within the mandated timeframe, without client permission for an extension.

In San Diego County this is relevant only for inpatient, day treatment, and outpatient services provided by fee-for-service providers, as these are currently the only services for which an authorization is required. Clients wishing to have a review of a clinical decision made by an individual provider, not the MHP or its administrative services organization, may use the grievance process.

The MHP is required to provide *Aid Paid Pending* for beneficiaries who want continued services, and have made a timely request for an appeal:

- within 10 days of the date the NOA was mailed, or
- within 10 days of the date the NOA was personally given to the beneficiary, or
- before the effective date of the service change, <u>whichever is later</u>.

The MHP must ensure that benefits are continued while the appeal is pending, if the beneficiary so requests. The beneficiary must have:

- an existing service authorization which has not lapsed and the service is being terminated, reduced, or denied for renewal by the MHP, or
- been receiving specialty mental health services under an 'exempt pattern of care' (see Section X. Definitions).

The benefits will stay the same until the period covered by the existing authorization expires, the date an appeal is resolved or a hearing decision is rendered, or the date on which the appeal or state fair hearing is otherwise withdrawn or closed, <u>whichever is earliest</u>.

VI. APPEAL PROCEDURES

1. The client may file the appeal orally or in writing. If the appeal is oral, the client is required to follow up with a signed, written appeal. The client shall be

provided with assistance in completing the written appeal, if requested. The date of the oral appeal begins the appeal resolution timeframe, regardless of when the follow-up, written appeal was signed. The client may present evidence in person or in writing.

2. CCHEA or USD Patient Advocacy Program, as appropriate, determines whether the appeal meets the criteria for expedited appeal and, if so, follows the expedited appeal process as stated in section VI below.

3. CCHEA or Patient Advocacy Program logs the appeal within one working day of receipt. The log shall include the:

   - client name or other identifier,
   - date the appeal was received,
   - date the appeal was logged,
   - nature of the appeal,
   - the provider involved,
   - and whether the issue concerns a child.

   The log is to be maintained in a confidential location at CCHEA or USD Patient Advocacy. If the client requests to see the log, CCHEA or USD will summarize in writing the content pertaining to the client.

4. CCHEA or USD shall acknowledge, in writing, receipt of the appeal within three working days.

5. CCHEA or USD shall contact the provider as soon as possible and within three working days of receipt of the client's written authorization to represent the client.

6. CCHEA or USD Patient Advocacy Program shall notify the QI Unit within three working days of any appeal filed.

7. CCHEA or USD evaluates the appeal and:

   - Ensures that the person who determines the final resolution of the appeal has had no decision-making involvement in any prior level of review.
   - Safeguards the client's confidentiality per all applicable laws.

     In cases where the CCHEA or USD staff member has another existing relationship with the client or provider, that contractor's Program Director shall reassign the case or consult with the MHP QI Unit about conflict of interest of issues.

8. If the appeal is about a clinical issue, the decision-maker must also be a mental health professional with the appropriate clinical expertise in treating the client's condition.

9. All County-operated programs and contracted providers are required by contract to cooperate with the problem resolution process as it is described herein. The full participation and timely cooperation of the provider are essential in honoring the

client's right to an efficient, effective problem resolution process. During the resolution of the client's appeal, CCHEA or USD staff will often find it necessary to discuss the issue with the providers involved and the Administrative Service Organization (ASO), either in person or by phone at various points in the process. The expectation is that CCHEA or USD, the ASO, and the provider will cooperate with each other to find mutually agreeable and expeditious ways to address and resolve the client's issue.

If CCHEA or USD denies the appeal, or if the appeal is granted but is not an appeal of one of the actions listed in Item #10 below, proceed to item #12.

10. If CCHEA or USD believes that there is sufficient merit to grant an appeal regarding an action that:

- denied or limited authorization of a requested service, including the type or level of service,
- reduced, suspended or terminated a previously authorized service, or
- denied, in whole or in part, payment for a service, CCHEA or USD shall do the following within 30 calendar days of the date the appeal was filed:

  a) notify the MHP Director or designee in writing of details of the appeal and the specific, supported rationale for why it should be granted, and
  b) provide copies to the MHP Director or designee of all relevant medical records, the clinical consultant's evaluation, case notes, and other materials including an accurate representation of the provider's position regarding the appeal.

11. The MHP Director or designee shall return a decision on the appeal to the advocacy organization within 10 calendar days of receipt of the above.

12. CCHEA or USD shall notify the beneficiary in writing regarding the disposition of the appeal within the timeframe for resolution stated below. The notice shall include:
    - the date,
    - the resolution,
    - and if the decision is not wholly in favor of the client AND the client is a Medi-Cal beneficiary, information regarding:
        - the right to request a State Fair Hearing within 90 days of notice of the decision,
        - how to request a State Fair Hearing, and
        - the beneficiary's right to request services while the hearing is pending and how to make that request for continued services.
        - A copy of the appeal resolution letter will be sent to the provider and the Quality Improvement (QI) Unit at the time the letter is sent to the client.

13. Appeals must be resolved within 45 calendar days from the date of receipt of the appeal. However, in some limited instances, it may be necessary for the timeframe to be extended by up to 14 calendar days for good cause, such as a satisfactory resolution is pending but not complete. Timeliness of appeal

resolution is an important issue for consumers. If an extension is required, CCHEA or Patient Advocacy Program will contact the client to discuss an extension, document clearly in the file the extenuating circumstances for the extension, and the date the client was contacted and agreed to an extension.

14. If the timeframe extension was not requested by the client, CCHEA or Patient Advocacy staff must give the client written notice of the reason for the delay. The notice shall include the client's right to file a grievance if the client disagrees with the decision to extend the timeframe.

15. If CCHEA or Patient Advocacy staff is unable to meet the timeframe described herein, they are required to issue an NOA-D to Medi-Cal beneficiaries only. A copy shall be sent to the QI Unit. CCHEA or USD Patient Advocacy Program shall record in the log the final disposition of the appeal, and the date the decision was sent to the client, or the reason for no final disposition of the appeal.

16. If the decision of the appeal process reverses a decision to deny services, those services shall be promptly provided.

Reminder: Providers shall not subject a client to any discrimination or any other penalty of any kind for filing an appeal.

APPEALS PROCESS

STEP	ACTION	TIMELINE
1	Appeal Filed by client	File Date
2	Appeal Logged	1 Working Day from Appeal
3	Expedited Appeal Criteria?	Go to Section VII
4	Written Acknowledgement of appeal to client	3 Working Days from Receipt of Appeal
5	Provider Contact	3 Working Days from Client's Written Permission to Represent
6	Clinical consultant review, if applicable	As soon as possible
7	Notify QI Unit	3 Working Days of Appeal Filing
8	Advocacy Organization recommends denying appeal	See #10 for timelines
9	Advocacy Organization recommends granting the appeal, and notifies MHP Director in writing with supporting documentation	Within 30 calendar days from date appeal was filed
10	MHP Director makes decision on the appeal	Within 10 calendar days from receipt of appeal.
11	**Appeal Resolution**	**45 Calendar Days from Receipt of Appeal**
12	Appeal Extension (if needed)	14 Calendar Days from Extension Filing Date

VIII. EXPEDITED APPEAL PROCESS—available to Medi-Cal beneficiaries only

When a client files an oral or written appeal to review an action (as previously defined) and use of the standard appeal resolution process could, in the opinion of the client, the MHP, or CCHEA or USD Patient Advocacy program staff, jeopardize the client's life, health or ability to

attain, maintain, or regain maximum function, the expedited appeal process will be implemented instead.

IX. EXPEDITED APPEAL PROCEDURES

1. The client may file the expedited appeal orally or in writing.
2. The CCHEA or Patient Advocacy Program logs the expedited appeal within one working day of receipt. The log shall include the:
   - client name or other identifier,
   - date appeal was received,
   - date the appeal was logged,
   - nature of the appeal,
   - provider involved,
   - and whether the issue concerns a child.
4. The log is to be maintained in a confidential location at CCHEA or USD Patient Advocacy. If the client requests to see the log, the advocacy agency will summarize in writing the content pertaining to the client.
5. CCHEA or Patient Advocacy Program provides the client a written acknowledgement of receipt of the expedited appeal within two working days.
6. CCHEA or Patient Advocacy Program shall notify the QI Unit immediately of any expedited appeal filed. CCHEA or Patient Advocacy Program shall contact the provider as soon as possible but not to exceed two working days.
7. The client or his or her representative may present evidence in person or in writing.
8. CCHEA or Patient Advocacy Program evaluates the expedited appeal.
   - They shall ensure that the person who determines the final resolution of the appeal has had no decision-making involvement in any prior level of review.
   - The client's confidentiality shall be safeguarded per all applicable laws.
9. If the expedited appeal is about a clinical issue, the decision-maker must also be a mental health professional with the appropriate clinical expertise in treating the client's condition.
10. If, in the opinion of CCHEA or Patient Advocacy Program, the appeal does not meet the criteria for the expedited appeal process that has been requested, CCHEA or Patient Advocacy program staff shall:
    - Obtain agreement of the MHP to deny the use of the expedited appeal process and to treat the appeal as a standard appeal instead.
    - Transfer the appeal to the timeframe for standard appeal resolution (above), and
    - Make reasonable efforts to give the client prompt oral notice of the denial of the expedited process, and follow up within two calendar days with a

written notice. A copy of the letter shall be sent to QI.

11. All County-operated programs and contracted providers are required by contract to cooperate with the problem resolution process as it is described herein. The full participation and timely cooperation of the provider are essential to honoring the client's right to an efficient, effective problem resolution process. During the resolution of the client's expedited appeal, CCHEA or USD staff will often find it necessary to discuss the issue with the providers involved, and the Administrative Service Organization (ASO), either in person or by phone at various points in the process. The expectation is that CCHEA or USD, the ASO, and the provider will cooperate with each other to find mutually agreeable and expeditious ways to address and resolve the client's issue.

    If CCHEA or USD denies the expedited appeal, or if the expedited appeal is granted but is not an appeal of one of the actions listed in item #12 below, *proceed to item #14.*

12. If the advocacy organization believes that there is sufficient merit to grant an expedited appeal regarding an action that:
    - denied or limited authorization of a requested service, including the type or level of service,
    - reduced, suspended or terminated a previously authorized service, or
    - denied, in whole or in part, payment for a service, the advocacy organization shall do the following within two working days of the date the appeal was filed:
        - notify the MHP Director or designee in writing of details of the expedited appeal and the specific, supported rationale for why it should be granted, and
        - provide copies to the MHP Director or designee of all relevant medical records, the clinical consultant's evaluation, case notes, and other materials including an accurate representation of the provider's position regarding the expedited appeal.

13. The MHP Director or designee shall return a decision on the expedited appeal to the advocacy organization within one working day of receipt of the above.

14. CCHEA or Patient Advocacy Program shall make a reasonable effort to notify the client orally of the expedited appeal resolution decision as soon as possible. In addition, they shall notify the client in writing within the timeframe for resolution stated below, regarding the results of the expedited appeal. The notice shall include:
    - the date,
    - the resolution,
    - and only if the decision is not wholly in favor of the client AND the client is a Medi-Cal beneficiary
    - information regarding the right to request an expedited State Fair Hearing
    - information on how to request continued services (aid paid pending) while the hearing is pending.

    A copy of the appeal resolution letter will be sent to the provider and the QI Unit

at the same time the letter is sent to the client.

15. Expedited appeals must be resolved and the client must be notified in writing within three working days from the date of receipt of the expedited appeal. However, in some limited instances, it may be necessary for the timeframe to be extended by up to 14 calendar days if the client requests an extension. In rare circumstances, the timeframe may be extended up to the 14 calendar days if CCHEA or USD staff determines that there is a need for more information AND that the delay is in the client's best interest.

16. If the timeframe extension was not requested by the client, CCHEA or USD Patient Advocacy staff must give the client written notice of the reason for the delay.

17. If CCHEA or USD staff is unable to meet the timeframe described herein, they shall issue an NOA-D to the beneficiary. A copy shall be sent to the QI Unit.

18. CCHEA or USD Patient Advocacy Program shall record in the log the final disposition of the expedited appeal, and the date the decision was sent to the client, or reason there has not been a final disposition of the expedited appeal.

19. If the decision of the appeal process reverses a decision to deny services, those services shall be promptly provided.

Reminder: Providers shall not subject a client to any discrimination or any other penalty of any kind for filing an appeal.

EXPEDITED APPEAL PROCESS

STEP	ACTION	TIMELINE
1	Expedited Appeal Filed by client	File Date
2	Expedited Appeal Criteria? If not, obtain MHP agreement and treat as regular appeal.	If no, notify client in 2 calendar days in writing
3	Expedited Appeal Logged	1 Working Day from Appeal receipt
4	Written Acknowledgement of appeal to client	2 Working Days from Receipt of Appeal
5	Provider Contact	2 Working Days from Client's Written Permission to Represent
6	Notify QI Unit	Immediately
7	Advocacy Organization recommends denying appeal	See #10 above for timelines
8	Advocacy Organization recommends granting the appeal, and notifies MHP Director in writing with supporting documentation.	Within 2 working days from date appeal was filed
9	MHP Director makes decision on the appeal	Within 1 working day from receipt of notification from the Advocacy Organization
10	Appeal Resolution	3 Working Days from Receipt of Appeal
11	Disposition Extension (if needed)	14 Calendar Days from 3rd working day.

X. STATE FAIR HEARING—available to Medi-Cal beneficiaries only, who are not receiving services through the Department of Education

A. A State Fair Hearing is a legal process that includes an impartial hearing and ruling by an administrative law judge. A Medi-Cal beneficiary is required to exhaust the MHP's problem resolution process above prior to requesting a State Fair Hearing. Only a Medi-Cal beneficiary may request a state hearing:

- within 90 days after the completion of the MHP beneficiary problem resolution process, whether or not the client received a Notice of Action (NOA), or
- when the grievance or appeal has not been resolved within mandated timelines, and who gave no permission for an extension. The beneficiary does not need to wait for the end of the MHP Problem Resolution process.

A Medi-Cal beneficiary may request a State Fair Hearing by writing to or calling the State Fair Hearings Division of the California Department of Social Services at 1(800) 952-5253, or by contacting CCHEA or USD Patient Advocacy Program for assistance.

Children and youth receiving mental health services under AB 3632/2726 legislation through the Department of Education should use that Department's Grievance and Appeals process.

B. When the MHP QI Unit has been notified by the State Fair Hearings Division that an appeal or state fair hearing has been scheduled, the QI Unit shall:

1. Contact the client or his or her advocate, investigate the problem, and try to resolve the issue before the matter goes to State Fair Hearing. In cases where a successful resolution of the matter is not reached, the client proceeds to a hearing.
2. Attend the hearing to represent the MHP position.
3. Require that County-operated and/or contracted providers involved in the matter assist in the preparation of a position paper for the hearing, and/or may be requested to attend the hearing as a witness in the case.
4. The MHP is required to provide *Aid Paid Pending* for beneficiaries who want continued services while awaiting a Hearing, have met the Aid Paid Pending criteria per CCR, Title 22, Section 51014.2 summarized below, and have made a timely request for a fair hearing:
    - within 10 days of the date the NOA was mailed, or
    - within 10 days of the date the NOA was personally given to the beneficiary, or
    - before the effective date of the service change, <u>whichever is later</u>.
5. The beneficiary must have:
    - an existing service authorization which has not lapsed and the service is being terminated, reduced, or denied for renewal by the MHP, or

- o been receiving specialty mental health services under an 'exempt pattern of care' (see Section XII. Definitions).

6. The benefits will stay the same until the period covered by the existing authorization expires, the date an appeal is resolved or a hearing decision is rendered, or the date on which the appeal or state fair hearing is otherwise withdrawn or closed, whichever is earliest.

7. After a judge has heard a case, he or she forwards the decision to the MHP QI Unit. In the event that the case is not resolved in the MHP's favor, the QI Unit staff shall communicate the decision and any actions to be implemented, to the MHP Program Monitors to oversee implementation of the resolution by the County-operated and/or contracted providers.

Please note: A beneficiary may file an appeal or state fair hearing whether or not a Notice of Action (NOA) has been issued.

XI. MONITORING GRIEVANCES AND APPEALS

The MHP QI Unit shall be responsible for monitoring grievances and appeals, identifying issues and making recommendations for needed system improvement.

A. Procedures

1. The MHP QI Unit shall review the files of CCHEA and USD Patient Advocacy program periodically and as frequently as needed in order to monitor timely adherence to the policy and procedures outlined herein, and ensure that consumer rights under this process are protected to the fullest extent.

2. On a monthly basis, by the 20th of the following month, USD Patient Advocacy Program and CCHEA shall submit their logs of all grievances and appeals for the previous calendar month, to the MHP QI Unit. The logs shall specify whether each item is a grievance, appeal, or expedited appeal. They shall include the:

   - client name or other identifier
   - date the grievance or appeal was filed,
   - date logged
   - nature of the grievance or appeal
   - provider involved,
   - and whether the issue concerns a child.

3. For those grievances and appeals that have been resolved, the log shall note the final disposition of the grievance or appeal, and the date the decision was sent to the client.

4. The MHP QI Unit will keep centralized records of monitoring grievances and appeals, including the nature of the grievance/appeal, as well as track

outcomes of appeals that were referred to other entities including State Fair Hearings. Trends will be identified and referred to the Quality Review Council, MHP Director, and/or Mental Health Board for recommendations or action as needed. The MHP QI Unit shall submit a grievance and appeal log to the State Department of Mental Health annually.

B. Handling Complaint Clusters

1. CCCHEA and USD Patient Advocacy shall report to the QI Unit complaint clusters about any one provider or therapist occurring in a period of several weeks or months, immediately upon discovery. Background information and copies of client documentation shall be provided to the QI Unit also.

2. The QI Unit will investigate all such complaint clusters.

3. Findings will be reported to the MHP Director.

XII. DEFINITIONS

ASO: Administrative Service Organization contracted by HHSA to provide Managed Care Administrative functions.

Action: As defined by 42 Code of Federal Regulations (CFR) an action occurs when the Mental Health Plan (MHP) does at least one of the following:

- Denies or limits authorization of a requested service, including the type or level of service;
- Reduces, suspends, or terminates a previously authorized service;
- Denies, in whole or in part, payment for a service;
- Fails to provide services in a timely manner, as determined by the MHP or;
- Fails to act within the timeframes for disposition of standard grievances, the resolution of standard appeals, or the resolution of expedited appeals.

Appeal: A request for review of an action (as action is defined above).

Beneficiary: A client who is Medi-Cal eligible and currently requesting or receiving specialty mental health services paid for under the County's Medi-Cal Managed Care Plan.

BENEFICIARY AND CLIENT PROBLEM RESOLUTION POLICY AND PROCESS

Client:	Any individual currently receiving mental health services from the County MHS system, regardless of funding source.
Consumer Center for Health Education and Advocacy (CCHEA):	CCHEA is an MHP contractor currently designated by the Local Mental Health Director to fulfill two roles: to operate the County's Grievance and Appeal process for client problems with outpatient and all other non-residential mental health services; and to provide patient advocacy services which include information and education on client rights and individual assistance for mental health clients with problems accessing/maintaining services in the community.
Consumer:	Any individual who is currently requesting or receiving specialty mental health services, regardless of the individual's funding source and/or has received such services in the past and/or the persons authorized to act on his/her behalf. (This includes family members and any other person(s) designated by the client as his/her support system.)
Grievance:	An expression of dissatisfaction about any matter other than an action (as action is defined).
Grievance and Appeal Process:	A process for the purpose of attempting to resolve consumer problems regarding specialty mental health services.
Mental Health Plan (MHP):	County of San Diego, Health & Human Services Agency, Mental Health Services.

Notice of Action (NOA):

A notice sent to Medi-Cal beneficiaries to inform them of a decision regarding denial, reduction, or termination of requested services and their rights for appeal if they disagree with the decision.

NOA-A: (Assessment) Denial of service sent from providers to Medi-Cal beneficiaries when the face-to-face assessment indicates they do not meet medical necessity criteria and no specialty mental health services will be provided.

NOA-B: (Denial of Services) Denial or modification of provider's request for Medi-cal services requiring pre-authorization. The denial is sent from the point of authorization to both provider and beneficiary, when the beneficiary did not receive the service.

NOA-C: (Post-Service Denials) Denial or modification of provider's request for specialty mental health services sent from the point of authorization to both the provider and the beneficiary, when the beneficiary has already received the service.

NOA-D: (Delayed Grievance/Appeal Decisions) Notice sent by advocacy contractor to the beneficiary when the resolution of the grievance, appeal or expedited appeal was not provided within the required timeframe.

NOA-E: (Lack of Timely Services) Notice sent by provider to beneficiary when the provider does not provide services in a timely manner according to the MHP standards for timely services.

Patients' Rights Advocate:

The persons designated under Welfare and Institutions Code, Section 5500 et seq. to protect the rights of all recipients of specialty mental health services. The Patients' Rights Advocate "shall have no direct or indirect clinical or administrative responsibility for any recipient of Medi-Cal Managed Care Services, and shall have no other responsibilities that would otherwise compromise his or her ability to advocate on behalf of specialty mental health beneficiaries."

USD Patient Advocacy Program staff currently serve as the Patients' Rights Advocate for acute inpatient and other 24-hour residential services, and CCHEA staff serve as the Patients' Rights Advocate for outpatient, day treatment, and all other services.

Quality Improvement (QI) Program:

The Quality Improvement Program is a unit within HHSA Mental Health Services whose duties include monitoring and oversight of the Grievance and Appeal Process.

State Fair Hearing:	A formal hearing before an administrative law judge, requested by a Medi-Cal beneficiary and conducted by the State Department of Social Services as described in Welfare and Institutions Code, Section 10950, and Federal Regulations Subpart E, Section 431.200 et seq.
University of San Diego (USD) Patient Advocacy Program:	The University of San Diego Patient Advocacy Program is an agency currently designated by the Local Mental Health Director to fulfill two roles: to operate the County's Grievance and Appeal process for client problems in acute care hospitals and residential services; and to provide patient advocacy services which include information and education on patient rights and individual client assistance in resolving problems with possible violations of patient's rights.

County of San Diego
Medi-Cal Specialty Mental Health Program
NOTICE OF ACTION
(Assessment)

Date: _____

To: _____, Medi-Cal Number: _____

The mental health plan for San Diego County has decided, after reviewing the results of an assessment of your mental health condition, that your mental health condition does not meet the medical necessity criteria to be eligible for specialty mental health services through the plan.

In the mental health plan's opinion, your mental health condition did not meet the medical necessity criteria, which are covered in the state regulations at Title 9, California Code of Regulations (CCR), Section 1830.205, for the reason checked below:

☐ Your mental health diagnosis as identified by the assessment is not covered by the mental health plan (Title 9, CCR, Section 1830.205(b)(1)).

☐ Your mental health condition does not cause problems for you in your daily life that are serious enough to make you eligible for specialty mental health services from the mental health plan (Title 9, CCR, Section 1830.205(b)(2)).

☐ The specialty mental health services available from the mental health plan are not likely to help you maintain or improve your mental health condition (Title 9, CCR, Section 1830.205(b)(3)(A) and (B)).

☐ Your mental health condition would be responsive to treatment by a physical health care provider (Title 9, CCR, 1830.205(b)(3)(C)).

If you agree with the plan's decision, and would like information about how to find a provider outside the plan to treat you, you may call and talk to a representative of your mental health plan at (800) 479-3339 or write to: Utilization Management, United Behavioral Health, P.O. Box 601370, San Diego, CA 92160-1370.

If you don't agree with the plan's decision, you may do one or more of the following:

You may ask the plan to arrange for a second opinion about your mental health condition. To do this, you may call and talk to a representative of your mental health plan at (800) 479-3339 or write to: Utilization Management, United Behavioral Health, P.O. Box 601370, San Diego, CA 92160-1370.

You may file an appeal with your mental health plan. For inpatient/residential services, you may call and talk to or write a representative of USD Patient Advocacy Program at (800) 479-2233, 5998 Alcala Park, UOP 304, San Diego, CA 92110. For outpatient and all other mental health services, you may call and talk to or write a representative of the Consumer Center for Health Education and Advocacy at (877) 734-3258, 1475 Sixth Avenue, 4th Floor, San Diego, CA 92101. Or you can follow the directions in the information pamphlet the mental health plan has given you. You must file an appeal within 90 days of the date of this notice. In most cases the mental health plan must make a decision on your appeal within 45 days of your request. You may request an expedited appeal, which must be decided within 3 working days, if you believe that a delay would cause serious problems with your mental health, including problems with your ability to gain, maintain or regain important life functions.

If you have questions about this notice, for inpatient/residential services, you may call and talk to or write a representative of USD Patient Advocacy Program at (800) 479-2233, 5998 Alcala Park, UOP 304, San Diego, CA 92110. For outpatient and all other mental health services, you may call and talk to or write a representative of the Consumer Center for Health Education and Advocacy at (877) 734-3258, 1475 Sixth Avenue, 4th Floor, San Diego, CA 92101.

If you are dissatisfied with the outcome of your appeal, you may request a State Fair Hearing. The other side of this form will explain how to request a hearing.

County of San Diego
Medi-Cal Specialty Mental Health Services Program
NOTICE OF ACTION

Date: _____

To: _____ Medi-Cal Number _____

The mental health plan for San Diego County has ☐ denied ☐ changed your provider's request for payment of the following service(s):

_____

The request was made by: (provider name) _____

The original request from your provider was dated _____

The mental health plan took this action based on information from your provider for the reason checked below:

☐ Your mental health condition does not meet the medical necessity criteria for psychiatric inpatient hospital services or related professional services (Title 9, California Code of Regulations (CCR), Section 1820.205).

☐ Your mental health condition does not meet the medical necessity criteria for specialty mental health services other than psychiatric inpatient hospital services for the following reason (Title 9, CCR, Section 1830.205): _____

_____

_____

☐ The service requested is not covered by the mental health plan (Title 9, CCR, Section 1810.345).

☐ The mental health plan requested additional information from your provider that the plan needs to approve payment of the proposed service. To date, the information has not been received.

☐ The mental health plan will pay for the following service(s) instead of the service requested by your provider, based on the available information on your mental health condition and service needs: _____

_____

☐ Other: _____

_____

<u>If you don't agree with the plan's decision, you may</u>:

1. You may file an appeal with your mental health plan. To do this, you may call and talk to a representative of your mental health plan at (800) 479-3339 or write to: Utilization Management, United Behavioral Health, P.O. Box 601370, San Diego, CA 92160-1370; or follow the directions in the information brochure the mental health plan has given you. You must file an appeal within 90 days of the date of this notice. In most cases the mental health plan must make a decision on your appeal within 45 days of your request. You may request an expedited appeal, which must be decided within 3 working days, if you believe that a delay would cause serious problems with your mental health, including problems with your ability to gain, maintain or regain important life functions. You can request that your services stay the same until an appeal decision is made. To keep your services you must file an appeal within 10 days of the date of this notice or before the effective date of the change in services, whichever is later. The services requested were previously approved by the plan for the period _____. The effective date for the change in these services is _____.

2. If you are dissatisfied with the outcome of your appeal, you may request a state hearing which may allow services to continue while you wait for the hearing. The other side of this notice explains how to request a hearing. You can request that your services stay the same until a hearing decision is made. To keep your services you must file an appeal within 10 days of the date of this notice or before the effective date of the change in services, whichever is later. The services requested were previously approved by the plan for the period _____. The effective date for the change in these services is _____. The services may continue while you wait for a resolution of your hearing.

3. You may ask the plan to arrange for a second opinion about your mental health condition. To do this, you may call and talk to a representative of your mental health plan at (800) 479-3339 or write to: Utilization Management, United Behavioral Health, P.O. Box 601370, San Diego, CA 92160-1370.

YOUR HEARING RIGHTS

You only have 90 days to ask for a hearing. The 90 days start either:

1. The day after we personally gave you this the mental health plan's appeal decision notice, OR
2. The day after the postmark date of this mental health plan's appeal decision notice.

Expedited State Hearings

It usually takes about 90 days from the date of your request to make a hearing decision. If you think this timing will cause serious problems with your mental health, including problems with your ability to gain, maintain or regain important life functions, you may request an expedited state hearing. **To request an expedited hearing, please check the first box in the right hand column of this page under HEARING REQUEST and include the reason why you are requesting an expedited hearing.** If your expedited hearing request is approved, a hearing decision will be issued within three working days of the date your request is received by the State Hearings Division.

To Keep Your Same Services While You Wait for a Hearing

- You must ask for a hearing within 10 days from the date the mental health plan's appeal decision notice was mailed or personally given to you or before the effective date of the change in services, whichever is later.
- Your Medi-Cal mental health services will stay the same until a final hearing decision is made which is adverse to you, you withdraw your request for a hearing, or the time period or service limits for your current services expire, whichever happens first.

State Regulations Available

State regulations, including those covering state hearings, are available at your local county welfare office.

To Get Help

You may get free legal help at your local legal aid office or other groups. For problems with inpatient and residential mental health services, call USD Patient Advocacy Program at 800-479-2233. For problems with outpatient and all other mental health services, call toll free the Consumer Center for Health Education and Advocacy at 877- 734-3258. You can ask about your hearing rights or free legal aid from the Public Inquiry and Response Unit:

Call toll free: 1-800-952-5253

If you are deaf and use TDD, call: 1-800-952-8349

Authorized Representative

You can represent yourself at the state hearing. You can also be represented by a friend, an attorney or anyone else you choose. You must arrange for this representative yourself.

Information Practices Act Notice (California Civil Code Section 1798, et seq.) The information you are asked to write in on this form is needed to process your hearing request. Processing may be delayed if the information is not complete. A case file will be set up by the State Hearings Division of the Department of Social Services. You have the right to examine the materials that make up the record for decision and may locate this record by contacting the Public Inquiry and Response Unit (phone number shown above). Any information you provide may be shared with the mental health plan, the State Departments of Health Services and Mental Health and with the U.S. Department of Health and Human Services (Authority: Welfare and Institutions Code, Section 14100.2)

HOW TO ASK FOR A STATE HEARING

The best way to ask for a hearing is to fill out this page. Make a copy of the front and back for your records. Then send this page to:

State Hearings Division
California Department of Social Services
P.O. Box 944243, Mail Station 19-37
Sacramento, CA 94244-2430

Another way to ask for a hearing is to call 1-800-952-5253. If you are deaf and use TDD, call 1-800-952-8349.

HEARING REQUEST

I want a hearing because of a Medi-Cal related action by the Mental Health Plan of San Diego County.

☐ Check here if you want an expedited state hearing and include the reason below.

Here's why: _____

_____

_____

_____

_____

_____

_____

☐ Check here and add a page if you need more space.

My Name: (print) _____

My Social Security Number: _____

My Address: (print) _____

_____

My Phone Number: (____) _____

My Signature: _____

Date: _____

I need an interpreter at no cost to me. My language or dialect is: _____

I want the person named below to represent me at this hearing. I give my permission for this person to see my records and to come to the hearing for me.

Name: _____

Address: _____

_____

Phone Number: (____) _____

Appendix G
Quality Improvement Program

Q.I. Confidential Information

QUALITY IMPROVEMENT – HHSA-MHS
ADULT/OLDER ADULT OUTPATIENT
MEDICATION MONITORING SCREENING TOOL

Q.I. Confidential Information

Please complete all boxes on this form with legible writing or type

Program:	**Psychiatrist:**
Client:	**Review Date:**
InSyst #:	**Reviewer:**
Med. Record #:	

	CRITERIA	COMPLIANCE YES	NO	N/A	COMMENTS
1.	Medication rationale and dosage is consistent with community standards.	☐	☐	☐	
2.	If labs were indicated, were they ordered, obtained, & acted upon.	☐	☐	☐	
3.	Physical health conditions and treatment considered when prescribing psychiatric medication.	☐	☐	☐	
4.	No more than 2 medications of each chemical class concurrently without a clearly documented rationale.	☐	☐	☐	
5.	Adverse drug reactions and/or side effects treated and managed effectively.	☐	☐	☐	
6.	A signed consent form evidences informed consent.	☐	☐	☐	
7.	Documentation is in accordance with prescribed medication.	☐	☐	☐	
	Documentation includes client's:				
8a.	Response to medication therapy.	☐	☐	☐	
8b.	Presence/absence of side effects.	☐	☐	☐	
8c.	Extent of client's adherence with the prescribed medication regime and relevant interventions.	☐	☐	☐	
8d.	Client's degree of knowledge regarding management of his/her medication(s).	☐	☐	☐	
TOTAL (Please total the YES/NO columns) ***Please complete a McFloop form if there are any variances.***					

Medication Monitoring Committee Minutes

Program Name:		**Meeting Date:**	
☐ Quarter 1 Jul 1 – Sep 30, 20_____	☐ Quarter 2 Oct 1 – Dec 31, 20_____	☐ Quarter 3 Jan 1 – Mar 31, 20_____	☐ Quarter 4 Apr 1 – Jun 30, 20_____
Screened by: ☐ County Pharmacy ☐ MM Committee			

Committee Members	**Print Name**	**Discipline**	**Sign Name**
Chairperson			
Members			

Description of Activities

_____ Total Number of records screened this quarter

_____ Total Number of variances identified

_____ Total Number of McFloops required _____# Approved/Completed _____# Outstanding
(please note that one McFloop form can be completed for one or more variances on a MM Screening Tool)

Please note that all McFloops are due within 30 days of each quarter reporting due date (e.g. quarter one July, Aug., Sept. reports due by Oct. 15; all McFloops due by Nov. 15)

Please fax your Medication Monitoring Reports to:
Quality Improvement Unit
County of San Diego, Adult/Older Adult MHS
Fax: (619) 563-2795

Or mail to:
Quality Improvement Unit
Attention: Medication Monitoring
County of San Diego, Adult/Older Adult MHS
P.O. Box 85524
San Diego, CA 92186-5524
Mail Stop: P531G

Q.I. Confidential Information

Medication Monitoring Feedback Loop Form

(McFloop)

TO: _____
Treating Physician

FROM: **Medication Monitoring Committee**

RE: **Program Name** _____
Patient Name _____
InSyst # _____

Summary of Recommendations/Requests for Action:

_____

Reviewer Signature & Discipline **Date**

Response/ Action taken by Treating Physician to Committee
(Written documentation/proof must be provided within 2 weeks)

_____

Physician Signature & Discipline **Date**

Verification of Physician Response

( ) Approved

( ) Disapproved (Forwarded to Medical Director)

_____

Reviewer Signature & Discipline **Date**

County of San Diego - Health and Human Services Agency

Mental Health Services

MONTHLY STATUS REPORT-NARRATIVE

due the 15th calendar day of the month via email: MHS-COTR.HHSA@sdcounty.ca.gov

For instructions please click on the RED Markers located at the upper right corner of each heading.

1. GENERAL INFORMATION:

Contractor Name		Program Type	
Program Name		Provider Type	
Contract Number		Report Period	
RU Number		Date Submitted	
Submitted By		Contact Phone	

2. PROGRAM DESCRIPTION:

3. ACTIVITIES, EVENTS & CO-OCCURING DISORDERS:

4. COMMUNITY OUTREACH /COLLABORATION WITH OTHER AGENCIES/EDUCATION REGARDING SERVICES:

Population Targeted		**Venue**	

5. PROGRAMMATIC ISSUES AND ACTIONS INITIATED TO SOLVE OR MITIGATE THEM:

6. EMERGING ISSUES OR POTENTIAL PROBLEMS:

7. QUALITY IMPROVEMENT ACTIVITIES:

County of San Diego - Health and Human Services Agency

MONTHLY STATUS REPORT-DATA

1. GENERAL INFORMATION:

Contractor Name		Program Type	
Program Name		Provider Type	
Contract Number		Report Period	
RU Number		Date Submitted	
Submitted By		Contact Phone	

2. SERVICE AND BILLING UNITS:

SERVICE FUNCTIONS	Service Units					Billing Units				
	Annual Budget	Prior Month YTD	Report Month Actual	YTD Actual	% of Objective Complete	Annual Budget	Prior Month YTD	Report Month Actual	YTD Actual	% of Objective Complete
MHS										
MED SUPPORT										
CRISIS INTERVENTION										
CM BROKERAGE										
REHABILITATION										
TOTAL	0	0	0	0	0%	0	0	0	0	0%
REP PAYEE										
MAA										
FIRST TIME CALLS										
REPEAT CALLS										
TRANSFER TO ACL										
IMD LONG TERM										
OTHER (SPECIFY)										
TOTAL	0	0	0	0	0%	0	0	0	0	0%
COMMENTS										

3. STATISTICAL INFORMATION:

Report Item	Report Month	Year to Date
Admissions - *Total number as of last day of report month.*		
Discharges - *Total number as of last day of report month.*		
Active cases - *Total active cases as of last day of report month.*		
Unduplicated clients - *Total unique served during report month.*		
Serious Incident Report - *Total for the report month.*		
Budgeted FTE Direct Service Staff - *Total number,* ***(excluding consultants).***		
Actual FTE Direct Service Staff - *Total number as of the last day of the report month.*		
Average Caseload per Actual Direct Service Staff FTE - *#active cases/#direct service.*		

ITEMS 4 AND 5 BELOW APPLY TO CHILDREN'S PROGRAM ONLY.

4. WAIT LIST REPORT:

Total Number on Waiting List	Waiting Time (WT) in Days	WT for Initial MD Evaluation in Days	Total Number of AB2726 Waiting

Comments:

5. FAMILIES PARTICIPATING IN FACE-TO-FACE THERAPY AT LEAST TWO TIMES PER MONTH:

Total Number of Families	Total Number of Participating Families	Percent of Participation

Comments:

County of San Diego - Health and Human Services Agency

MONTHLY STATUS REPORT-OUTCOMES

1. GENERAL INFORMATION:

Contractor Name		Program Type	
Program Name		Provider Type	
Contract Number		Report Period	
RU Number		Date Submitted	
Submitted By		Contact Phone	

2. MHRTS (MENTAL HEALTH RECOVERY TREATMENT SCALE)

Base Month	Base Total	OutCome Month	YES	NO	DC	PD	Y+N	Rate	Total
Jul-06		Jan-07							0
Aug-06		Feb-07							0
Sep-06		Mar-07							0
Oct-06		Apr-07							0
Nov-06		May-07							0
Dec-06		Jun-07							0
Jan-07		Jul-07							0
Feb-07		Aug-07							0
Mar-07		Sep-07							0
Apr-07		Oct-07							0
May-07		Nov-07							0
Jun-07		Dec-07							0
	0		**0**	**0**	**0**	**0**	**0**	**0%**	**0**

3. SATS-R (SUBSTANCE ABUSE TREATMENT SCALE - REVISED)

Base Month	Base Total	OutCome Month	YES	NO	DC	PD	Y+N	Rate	Total
Jul-06		Jan-07							0
Aug-06		Feb-07							0
Sep-06		Mar-07							0
Oct-06		Apr-07							0
Nov-06		May-07							0
Dec-06		Jun-07							0
Jan-07		Jul-07							0
Feb-07		Aug-07							0
Mar-07		Sep-07							0
Apr-07		Oct-07							0
May-07		Nov-07							0
Jun-07		Dec-07							0
	0		**0**	**0**	**0**	**0**	**0**	**0%**	**0**

4. RESIDENTIAL STATUS OUTCOME

Base Month	Base Total	OutCome Month	YES	NO	DC	PD	Y+N	Rate	Total
Jul-06		Jan-07							0
Aug-06		Feb-07							0
Sep-06		Mar-07							0
Oct-06		Apr-07							0
Nov-06		May-07							0
Dec-06		Jun-07							0
Jan-07		Jul-07							0
Feb-07		Aug-07							0
Mar-07		Sep-07							0
Apr-07		Oct-07							0
May-07		Nov-07							0
Jun-07		Dec-07							0
	0		**0**	**0**	**0**	**0**	**0**	**0%**	**0**

5. EMPLOYMENT STATUS OUTCOME

Base Month	Base Total	OutCome Month	YES	NO	DC	PD	Y+N	Rate	Total
Jul-06		Jan-07							0
Aug-06		Feb-07							0
Sep-06		Mar-07							0
Oct-06		Apr-07							0
Nov-06		May-07							0
Dec-06		Jun-07							0
Jan-07		Jul-07							0
Feb-07		Aug-07							0
Mar-07		Sep-07							0
Apr-07		Oct-07							0
May-07		Nov-07							0
Jun-07		Dec-07							0
	0		**0**	**0**	**0**	**0**	**0**	**0%**	**0**

5. EDUCATION STATUS OUTCOME

Base Month	Base Total	OutCome Month	YES	NO	DC	PD	Y+N	Rate	Total
Jul-06		Jan-07							0
Aug-06		Feb-07							0
Sep-06		Mar-07							0
Oct-06		Apr-07							0
Nov-06		May-07							0
Dec-06		Jun-07							0
Jan-07		Jul-07							0
Feb-07		Aug-07							0
Mar-07		Sep-07							0
Apr-07		Oct-07							0
May-07		Nov-07							0
Jun-07		Dec-07							0
	0		**0**	**0**	**0**	**0**	**0**	**0%**	**0**

County of San Diego - Health and Human Services Agency

Mental Health Services

MONTHLY STATUS REPORT-SUGGESTION & TRANSFER

due the 15th calendar day of the month via email: MHS-COTR.HHSA@sdcounty.ca.gov

For instructions please click on the RED Markers located at the upper right corner of each heading.

1. General Information

Contractor Name		Program Type	
Program Name		Provider Type	
Contract Number		Report Period	
RU Number		Date Submitted	
Submitted By		Contact Phone	

2. Suggestion and Transfer Data

Date Received or Initiated **mm/dd/yy**	Indicate if this is Client **(S)** Suggestion or **(T)** Transfer Request	Client Suggestion Code **1-15**	Transfer Request Code **1-11**	Indicate if Client Transfer Request is **(O)** Out of Program or **(N)** To New Provider within the Program	Description of Client Suggestion or Transfer Request	Date of Resolution **mm/dd/yy**	Describe Resolution or Action Taken

County of San Diego - Health and Human Services Agency

MONTHLY STATUS REPORT-MEDICARE PART "D"

1. GENERAL INFORMATION:

Contractor Name		Program Type	
Program Name		Provider Type	
Contract Number		Report Period	
RU Number		Date Submitted	
Submitted By		Contact Phone	

2. MEDICARE PART "D" DATA:

Data Elements		Comments
What is the current caseload for:		
Dual eligibles (Medi-Medi)		
Medicare only		
Total		
Has the program been affected by Medicare Part D?		
YES		
NO		
If YES, mark all issues that apply by an "X":		
Medication not on Formulary		
Difficulty with payment (copay, premium, etc)		
Difficulty with enrolling/changing plans		
Access to physical medications		
Increase in Hospital or START program admissions		
Increase in serious incidents		
Other:		

County of San Diego - Health and Human Services Agency

MONTHLY STATUS REPORT-STAFFING AND PERSONNEL

1. GENERAL INFORMATION:

Contractor Name		Program Type	
Program Name		Provider Type	
Contract Number		Report Period	
RU Number		Date Submitted	
Submitted By		Contact Phone	

2. STAFFING UPDATES

3. PERSONNEL LISTING

Position	Name	Credential	Position Type Code	Budgeted FTE	Actual FTE	Ethnicity Code	Language Prof Code	Read & Write Prof	Specialty Code	Hire Date	Terminate Date	CC Training Attended	CC Trng Course Attended

County of San Diego - Health and Human Services Agency

TRAINING REPORT

1. GENERAL INFORMATION:

Contractor Name		Program Type	
Program Name		Provider Type	
Contract Number		Report Period	
RU Number		Date Submitted	
Submitted By		Contact Phone	

2. TRAINING REPORT

Training Course Designation	Course Topic or Description	Training Provided by **(C)** County or **(N)** NonCounty	Course Length (number of hours) **0.5** to **40.0**	Course Date Enter Actual Course Start Date **mm/dd/yy**	Number of Attendees by Function				Type of Training
					Administration or Management	Direct Services	Support Services	Volunteer or Student Workers	

County of San Diego - Health and Human Services Agency

MONTHLY STATUS REPORT-NOTICE OF ACTION-A

1. General Information

Contractor Name		Program Type	
Program Name		Provider Type	
Contract Number		Report Period	
RU Number		Date Submitted	
Submitted By		Contact Phone	

2. Notice of Action - Assessment (NOA-A)

Date	ID Number	Client Response

County of San Diego
Adult and Older Adult Mental Health Services

QUALITY IMPROVEMENT SERIOUS INCIDENT REPORT

To be completed and submitted via facsimile to Quality Improvement Department within 72 hours of occurrence of incident

Client Name: _____

Client InSyst Number: _____ Birth Date: _____

Diagnosis (use DSM IV Codes): Axis I (primary): __ __ __ __ __ Axis I (secondary): __ __ __ __ __

Provider Name: _____

Parent Organization (if any): _____

Date of Incident: _____ Time of Incident: _____

Location Where Incident Occurred: _____

Date Incident Was Reported to the Provider: _____

Date and Time Incident Reported Telephonically to County QI Department: _____

_____

1. INCIDENT REVIEWED (Please Check One):

☐ Adverse drug reaction resulting in severe physical damage and/or loss of consciousness, respiratory and /or circulatory difficulties requiring medical attention

☐ Suicide attempt resulting in severe physical damage and/or loss of consciousness, respiratory and /or circulatory difficulties requiring medical attention

☐ Medication error resulting in severe physical damage and/or loss of consciousness, respiratory and /or circulatory difficulties requiring medical attention

☐ Injurious assault on a client occurring on the program's premises resulting in severe physical damage and/or loss of consciousness, respiratory and /or circulatory difficulties requiring medical attention

☐ Injurious assault by a client occurring on the program's premises resulting in severe physical damage and/or loss of consciousness, respiratory and /or circulatory difficulties requiring medical attention

☐ Use of physical restraints*

☐ Felony arrests or convictions occurring while client is enrolled to mental health services*

☐ Death excluding natural cause, includes death by suicide

☐ Serious physical injury resulting in a client experiencing severe physical damage and/or loss of consciousness, respiratory and/or circulatory difficulties requiring medical attention

Client Name: _____

☐ Sexual assault on a client

☐ Other: _____

*Not reportable for SDCPH/EPU/PERT

2. DESCRIBE THE SERIOUS INCIDENT:
(Include people involved and precipitating factors. Indicate if client was admitted to acute care medical &/or psychiatric unit and length of stay.)

3. OTHER MENTAL HEALTH SERVICES CLIENT CURRENTLY RECEIVING:
(Outpatient, case management, medication management, day rehabilitation, etc.)

4. CURRENT PRESCRIBED MEDICATION AND DOSAGE:

5. PHYSICAL OR MEDICAL CONCERNS:

_____
Report Completed By Date

_____ _____
Program Manager Signature Date Telephone

_____
Date Faxed to Quality Improvement Department

Fax #: (619) 563-2795
SD County Mental Health Administration
Adult Quality Improvement Department
Telephone #: (619) 563-2781 or (619) 563-2747

County of San Diego
Adult and Older Adult Mental Health Services

QUALITY IMPROVEMENT
SERIOUS INCIDENT REPORT OF FINDINGS

To be completed and submitted to Quality Improvement Department within 30 (thirty) days of occurrence of incident

Program Name: _____
Client Name: _____
Client Insyst Number: _____
Date of Incident: _____

1. SUMMARY OF FINDINGS:
(Outline any clinical case conferences, meetings or investigations you may have conducted. Also attach copies of related newspaper articles, coroner's and toxicology reports, etc.)

2. POST COMMITTEE RECOMMENDATIONS/ PLANNED IMPROVEMENTS:

_____
Report Completed By Date

_____ _____
Program Manager Signature Date Telephone

_____
Date Faxed/Mailed to the address below:

Fax # (619) 563-2795 Tel.# (619) 563-2781
Address: SD County Mental Health Administration
Adult Quality Improvement Department
P.O. Box 85524 MS: P-531G
San Diego, CA 92186-5524

APPEAL PROCESS
Medi-Cal QI Recoupment Report
County of San Diego Adult Mental Health Services

Adult Quality Improvement has developed the following 2-level process for a provider who wishes to appeal a Medi-Cal recoupment decision.

1. Adult QI Specialist will mail the provider a formal written report outlining the results of their medical record review within 14 days of review completion.

2. Provider has 14 days from date of the cover letter attached to the written report to request a first level appeal.

3. First level appeal must be in writing, specify which recoupment(s) is being appealed, reason why, and include any supporting documentation from the medical record. Appeal should be marked "confidential" and mailed to Victoria Hilton, QI Program Manager.

4. First level appeal decision will be made within 7 working days from receipt of appeal letter. Provider will be informed of this decision in writing.

5. Should provider disagree with first level decision, provider has 7 working days from receipt of written decision to request a second level appeal. Second level appeal must be in writing, specify which recoupment(s) is being appealed from first level decision, and reason why. Appeal should be marked "confidential" and mailed to Candace Milow, QI Director.

6. Second level appeal decision will be made within 7 working days from receipt of appeal letter. Provider will be informed of this decision in writing.

Mailing address for Adult Quality Improvement:
County of San Diego
Adult Mental Health Services
P.O. Box 85524 Mailstop: P-531G
San Diego, CA 92186-5524

Any questions regarding this procedure may be directed to Victoria Hilton at (619) 563-2747.

QI:vh:02/18/05

ACTIONS REGARDING
REASONS FOR RECOUPMENT, FY 05-06

Reason	Adjustment to Cost Report	Service Deletion	Re-entry of service by provider
MEDICAL NECESSITY			
Documentation does not establish:			
An included diagnosis	☒	☐	☐
Impairment criteria	☒	☐	☐
Proposed intervention to address the impairment	☒	☐	☐
Expectation intervention will diminish impairment, prevent significant deterioration, or allow child to progress developmentally	☒	☐	☐
CLIENT/SERVICE PLAN			
Initial plan not completed within time period	☒	☐	☐
Not updated within time period	☒	☐	☐
No documentation of client participation/agreement	☒	☐	☐
PROGRESS NOTES			
No note for service claimed	☐	☒	☐
Time claimed greater than time documented	☐	☒	☒
Service provided where ineligible for FFP or in setting subject to lockouts	☐	☒	☒ (as non-billable)
TBS provided in juvenile hall	☐	☒	☒ (as non-billable)
Service provided solely academic, vocational, recreation, socialization	☐	☒	☒ (as non-billable)
Claim for group activity not properly apportioned	☐	☒	☒
Does not contain signature	☒	☐	☐
Service provided solely transportation	☐	☒	☒ (as non-billable)
Service provided solely clerical	☐	☒	☒ (as non-billable)
Service provided solely payee related	☐	☒	☒ (as non-billable)
"No show" billed (over zero minutes) when no treatment service provided	☐	☒	☒ (as InSyst code 299)

Appendix H
Cultural Competence

Appendix I
Management Information System

Appendix J
Provider Contracting

CALIFORNIA DEPARTMENT OF MENTAL HEALTH

REASONS FOR RECOUPMENT IN FY'05-06

NON-HOSPITAL SERVICES

MEDICAL NECESSITY:

1. Documentation in the chart does not establish that the beneficiary has a diagnosis contained in Section 1830.205(b)(1)(A-R).

   CCR, Title 9, Chapter 11, Section 1830.205(b)(1)(A-R)

2. Documentation in the chart does not establish that, as a result of a mental disorder listed in Section 1830.205(b)(1)(A-R), the beneficiary has, at least, one of the following impairments:

   - A significant impairment in an important area of life functioning
   - A probability of significant deterioration in an important area of life functioning
   - A probability the child will not progress developmentally as individually appropriate
   - For full-scope Medi-Cal (MC) beneficiaries under the age of 21 years, a condition as a result of the mental disorder that specialty mental health services can correct or ameliorate

   CCR Title 9, Chapter 11, Sections 1830.205(b)(2)(A),(B),(C) and 1830.210(a)(3)

3. Documentation in the chart does not establish that the focus of the proposed intervention is to address the condition identified in CCR, Title 9, Chapter 11, Sections 1830.205(b)(2)(A),(B),(C)—(see below):

   - A significant impairment in an important area of life functioning
   - A probability of significant deterioration in an important area of life functioning
   - A probability the child will not progress developmentally as individually appropriate
   - For full-scope MC beneficiaries under the age of 21 years, a condition, as a result of the mental disorder, that specialty mental health services can correct or ameliorate

   NOTE: EPSDT services may be directed toward the substance abuse disorders of EPSDT-eligible children who meet the criteria for specialty mental health services under this agreement, if such treatment is consistent with the goals of the mental health treatment and services are not otherwise available.

   CCR, Title 9, Chapter 11, Sections 1830.205(b)(3)(A)

REASONS FOR RECOUPMENT
IN FY '05-06

MEDICAL NECESSITY (con't):

4. Documentation in the chart does not establish the expectation that the proposed intervention will do, at least, one of the following:

    - Significantly diminish the impairment
    - Prevent significant deterioration in an important area of life functioning
    - Allow the child to progress developmentally as individually appropriate
    - For full-scope M/C beneficiaries under the age of 21 years, correct or ameliorate the condition

    CCR, Title 9, Chapter 11, Sections 1830.205(b)(3)(B)(1),(2), and (3)

CLIENT PLAN:

5. Initial client plan was not completed within time period specified in MHP's documentation guidelines, or, lacking MHP guidelines, within 60 days of intake unless there is documentation supporting the need for more time.

    MHP Contract, Exhibit A, Attachment 1, Appendix C

6. Client plan was not completed, at least, on an annual basis as specified in MHP's documentation guidelines.

    MHP Contract, Exhibit A, Attachment 1, Appendix C

7. No documentation of client or legal guardian participation in the plan or written explanation of the client's refusal or unavailability to sign as required in the MHP Contract with the DMH.

    MHP Contract, Exhibit A, Attachment 1, Appendix C

8. For beneficiaries receiving TBS, no documentation of a plan for TBS.
    DMH Letter No. 99-03, pages 6-7

PROGRESS NOTES:

9. No progress note was found for service claimed.
    CCR, Title 9, Chapter 11, Section 1810.440(c); MHP Contract, Exhibit A, Attachment 1, Appendix C

10. The time claimed was greater than the time documented.

    CCR, Title 9, Chapter 11, Section 1810.440(c); MHP Contract, Exhibit A, Attachment 1, Appendix C

REASONS FOR RECOUPMENT
IN FY '05-06

PROGRESS NOTES (con't):

11. The progress note indicates that the service was provided while the beneficiary resided in a setting where the beneficiary was ineligible for FFP, e.g., Institute for Mental Disease, jail, and other similar settings, or in a setting subject to lockouts per Title 9, Chapter 11.

    CCR, Title 9, Chapter 11, Sections 1840.312(g)&(h) and 1840.360-374; CFR, Title 42, Sections 435.1008 and 435.1009; and CCR, Title 22, Section 50273(1-9)

12. The progress note clearly indicates that the service was provided to a beneficiary in juvenile hall and when ineligible for MC. (Dependent minor is MC eligible. Delinquent minor is only MC eligible after adjudication for release into community.)

    CFR, Title 42, Sections 435.1008 and 435.1009; and CCR, Title 22, Section 50273(1-9)

13. The progress note indicates that the service provided was solely for one of the following:

    a) Academic educational service
    b) Vocational service that has work or work training as its actual purpose
    c) Recreation
    d) Socialization that consists of generalized group activities that do not provide systematic individualized feedback to the specific targeted behaviors

    CCR, Title 9, Chapter 11, Section 1840.312(a),(b),(c), and (d)

14. The claim for a group activity was not properly apportioned to all clients present.

    CCR, Title 9, Chapter 11, Section 1840.316)b)(2)

15. The progress note does not contain the signature (or electronic equivalent) of the person providing the service.

    MHP Contract, Exhibit A, Attachment 1, Appendix C

16. The progress note indicates the service provided was solely transportation.

    CCR, Title 9, Chapter 11, Sections 1810.355(a)(1)(B), 1840.312(f), and 1810.247, and 1840.110(a)

17. The progress note indicates the service provided was solely clerical.

    CCR, Title 9, Chapter 11, Sections 1840.312(f), and 1810.247, 1840.110(a), and 1830.205(b)(3)

18. The progress note indicates the service provided was solely payee related.

    CCR, Title 9, Chapter 11, Sections 1840.312(f), and 1810.247, 1840.110(a), and 1830.205(b)(3)

19. No service provided: Missed appointment per DMH Letter No. 02-07.

    DMH Letter No. 02-07

REASONS FOR RECOUPMENT
IN FY '05-06

PROGRESS NOTES (con't):

20. For beneficiaries receiving TBS, the TBS progress notes overall clearly indicate that TBS was provided solely for one of the following reasons:

    a) For the convenience of the family, caregivers, physician, or teacher
    b) To provide supervision or to ensure compliance with terms and conditions of probation
    c) To ensure the child's/youth's physical safety or the safety of others, e.g., suicide watch
    d) To address conditions that are not a part of the child's/youth's mental health condition

    DMH Letter No. 99-03, page 4

21. For beneficiaries receiving TBS, the progress note clearly indicates that TBS was provided to a beneficiary in a hospital mental health unit, psychiatric health facility, nursing facility, or crisis residential facility.

    DMH Letter No. 99-03, page 5

HOSPITAL SERVICES

MEDICAL NECESSITY:

22. Documentation in the chart does not establish that the beneficiary has a diagnosis contained in Section 1820.205(a)(1)(A-R).

    CCR, Title 9, Chapter 11, Section 1820.205(a)(1)(A-R)

23. Documentation in the chart does not establish that, as a result of a mental disorder listed in Section 1820.205(a)(1)(A-R), the beneficiary requires psychiatric inpatient hospital services for, at least, one of the following reasons:

    - Presence of symptoms or behaviors that represent a current danger to self or others, or significant property destruction
    - Presence of symptoms or behaviors that prevent the beneficiary from providing for, or utilizing, food, clothing or shelter
    - Presence of symptoms or behaviors that present a severe risk to the beneficiary's physical health
    - Presence of symptoms or behaviors that represent a recent, significant deterioration in ability to function
    - Need for psychiatric evaluation, medication treatment, or other treatment that can reasonably be provided only if the beneficiary is in a psychiatric inpatient hospital

REASONS FOR RECOUPMENT
IN FY '05-06

MEDICAL NECESSITY (con't):

- Presence of either a serious adverse reaction to medications or the need for procedures/therapies that require continued psychiatric inpatient hospitalization

CCR, Title 9, Chapter 11, Sections 1820.205(a)(2)(B) 1 a-d, 1820.205(a)(2)(B) 2 a-c, and 1820.205(b)(1-4)

ADMINISTRATIVE DAY:

24. Documentation in the chart does not establish that the beneficiary previously met medical necessity criteria for acute psychiatric inpatient hospital service during the current hospital stay.

CCR, Title 9, Chapter 11, Sections 1820.220(j)(5) and 1820.225(d)(2

25. Documentation in the chart does not establish that the hospital made the minimum number of contacts with the non-acute residential treatment facilities as evidenced by a lack of the following: a) The status of the placement option(s), b) the dates of the contacts, and c) the signature of the person making each contact.

CCR, Title 9, Chapter 11, Sections 1820.220(j)(5) and 1820.225(d)(2)

CLIENT PLAN:

26. The beneficiary record does not contain a client plan.

Code of Federal Regulations (CFR), Title 42, Subchapter C, Subpart D, Sections 456.180; CCR, Title 9, Chapter 11, Section 1820.210

27. The client plan was not signed by a physician.

CFR, Title 42, Subchapter C, Subpart D, Sections 456.180; CCR, Title 9, Chapter 11, Section 1820.210

OTHER:

28. A claim for a day when the beneficiary was not admitted to the hospital.

CCR, Title 9, Chapter 11, Sections 1810.238, 1820.205, and 1840.110(a) (b)(2)(A),(B),(C) and 1830.210(a)(3)

San Diego County Mental Health Services
Provider Self Reported Disallowance Claim Form

Confidential

Reporting Unit:

Provider #:

Program:

Contact Person:

Contact Person's number: **Email Address:**

Date Requested:

Client #	Procedure Code	Date of Service	Time In Minutes	Cost	Reason for Disallowance (Use Reasons for Recoupment) 1	Service Deletion2	Status (County Use Only)

E-mail completed form to: Mental Health Administration Financial Management Unit

1 FFP must be recouped for all service disallowances.

2 Mark this box with an X for services listed on "Reasons for Recoupment" as service deletion.

3 For services that need to be entered correctly, Providers are required to re-enter into InSyst.

A.J.3

Date Recieved

County Staff Signature

Date Entered

Confidential

PROVIDER ACTIONS
FOR
BILLING DISALLOWANCES AND SERVICE DELETIONS

Reason	*Disallow Billing*	*Delete Service*	*Provider Re-enter Service*
Medical Necessity:			
1.Documentation does not establish an included diagnosis	X		*No re-entry for this reason.*
2. Documentation does not establish impairment criteria	X		*No re-entry for this reason.*
3. Documentation does not establish proposed intervention to address the impairment	X		*No re-entry for this reason.*
4. Documentation does not extablish expectation intervention will diminish impairment, prevent significant deterioration, or allow child to progress developmentally	X		*No re-entry for this reason.*
Client/Service Plan:			
5. Initial plan not completed within time period	X		*No re-entry for this reason.*
6. Not updated within time period	X		*No re-entry for this reason.*
7. No documentation of client participation/agreement	X		*No re-entry for this reason.*
Progress Notes:			
8. No note for service claimed	X	X	*No re-entry for this reason.*
9. Time claimed greater than time documented	X	X	*Re-enter corrected time.*
10. Service provided were ineligible for FFP(Federal Finiancial Participation) or in setting subject to lockouts (i.e. service provided while client was in an IMD, Jail, Juvenile Hall, etc…)	X	X	*Re-enter as non-billable.*
11. TBS provided in juvenile hall	X	X	*Re-enter as non-billable.*
12. Service provided was solely academic, vocational, recreation, socialization	X	X	*Re-enter as non-billable.*
13. Claim for group activity was not properly apportioned	X	X	*Re-enter corrected time.*
14. Does not contain a signature	X		*No re-entry for this reason.*
15. Service provided was solely transportation	X	X	*Re-enter as non-billable.*
16. Service provided was solely clerical	X	X	*Re-enter as non-billable.*
17. Service provided was solely payee related	X	X	*Re-enter as non-billable.*
18. "No Show" billed (over zero minutes) when no treatemt service provided	X	X	*Re-enter as non-billable.*
Data Entry:			
19. Data entry error	X	X	*Re-enter corrected service.*
20. Documentation done 14 days after date of service	X	X	*Re-enter as non-billable.*

Appendix K
Provider Issue Resolution

FORMAL COMPLAINT BY PROVIDER

Provider's Name	
Program Manager	
Agency	
Address	
Phone	
Fax	

FORMAL COMPLAINT BY PROVIDER **Forward Copy to QI Unit**
Date:
To:
From:
Summary and date on which issue(s) was attempted to be resolved informally (if applicable):
Outline of formal complaint/concern including all relevant data and comments, which support issue(s).
Formal complaint shall be submitted within 90 calendar days of original attempt to resolve issues(s) informally. Attach any applicable document(s).

FORMAL RESPONSE TO COMPLAINT	**Forward Copy to QI Unit**
Date:	
To:	
From:	
Response to complaint/concern, which includes a statement of the reason(s) for the decision that addresses each issue, raised by the provider, and any action required by the provider to implement the decision.	
Program Monitor/Chief shall have 60 calendar days from the receipt of the written complaint to inform the provider in writing of the decision.	

FORMAL APPEAL BY PROVIDER	**Forward Copy to QI Unit**
Date:	
To:	
From:	
Formal Provider Appeal may be submitted to the Mental Health Contracts Manager at any time.	
Outline summary of issue(s) and support for appeal with any needed attachment(s).	
When a formal complaint process was utilized, appeal shall be submitted to the Mental Health Contracts Manager within 30 calendar days of formal complaint response.	

FORMAL APPEAL RESPONSE	**Forward Copy to QI Unit**
Date:	
To:	
From:	
Response to complaint/concern which includes a statement of the reasons for the decision that addresses each issue raised by the provider, and any action required by the provider to implement the decision.	
Mental Health Contracts Manager shall have 60 calendar days from the receipt of the written appeal to inform the provider in writing of the decision.	

Appendix L
Practice Guidelines

Appendix M
Staff Qualifications and Supervision

MENTAL HEALTH PROFESSIONAL LICENSING WAIVER REQUEST

MH 12 (Rev 11/03)

PROFESSIONAL LICENSING WAIVER REQUEST

Instructions for completing this form:

1) *Applicant's Full Name, Include Aliases and Maiden Names:* DMH staff need this information, when applicable, to accurately track the applicant's waiver history. At the option of the county, a waiver granted in one county is valid in another county for the life of the waiver. Rather than requesting a new waiver, when applicable, a county can obtain a copy of the previous waiver.

2) *Type of Waiver Request*: Clearly indicate the type of waiver request. The applicant will receive the maximum waiver period, unless requested otherwise by the county—five years Psychologists who are gaining experience for licensure or three years for individuals who were recruited from outside of California. (To be eligible for the Out-of-State/License-ready category, an applicant must be both license-ready and recruited from out-of-state.)

3) *Date of Degree or Date all Degree Requirements Were Met:* Attach a copy of the applicant's degree or a letter from the applicant's alma mater specifying the date the applicant met all the requirements for the doctorate degree. This is important in determining the commencement of the waiver period. A waiver cannot be granted prior to the degree date or the date the applicant met all the requirements for the doctorate degree.

4) *Employment Start Date (In the Position Requiring the Waiver):* Specify the date the applicant started or will start employment in the position requiring a waiver. The waiver time period (three or five years) will commence on this date unless the applicant had been previously employed in a local mental health program (county or contract) in a position that required a license. If the applicant has been so previously employed, the waiver time period will commence on the date of the previous employment.

   In order for the DMH to determine if the applicant has been previously employed in a position requiring a waiver, it is necessary to attach a copy of the applicant's post-degree employment history. This can take the form of a current, complete resume or recent employment application. In addition, the DMH will check for a previously issued waiver.

   While the waiver period commences as explained above, the waiver is not effective until a complete waiver application is received in the Medi-Cal Oversight regional office or the date of employment, whichever is later.

   Normally, the maximum period of time for a waiver is either three or five years, whichever is applicable. However, the Department will consider a request for an additional period of time when documentation supports the presence of extenuating circumstances that have resulted in a significant amount of time away from work.

5) *Request Submitted by (Local Mental Health Director/Designee Signatue, County and Date):* All waiver requests must be submitted, signed and dated by the local county mental health director or the director's designee.

For additional information on the professional licensing waiver process, see DMH Letter No. 02-09.

MENTAL HEALTH PROFESSIONAL LICENSING WAIVER REQUEST

MH 12 (Rev 11/03)

(Please fill-in all boxes below. See reverse side for completion instructions.)

APPLICANT'S FULL NAME, (Include aliases and maiden names):	
TYPE OF WAIVER REQUEST **(Please check appropriate box)**	
PSYCHOLOGIST: (5 years maximum) ☐	OUT-OF-STATE/LICENSE READY: (3 years maximum) PSYCHOLOGIST ☐ LCSW ☐ MFT ☐
DATE OF DEGREE OR DATE ALL DEGREE REQUIREMENTS MET:	EMPLOYMENT START DATE (in the position requiring the waiver):
REQUEST SUBMITTED BY: (SIGNATURE-MENTAL HEALTH DIRECTOR/DESIGNEE)	
DATE:	COUNTY:

DO NOT COMPLETE THE FOLLOWING - FOR STATE DEPARTMENT OF MENTAL HEALTH USE ONLY

DATE WAIVER EXPIRES:	DATE COMPLETE WAIVER APPLICATION RECEIVED:
COMMENTS: (if denied, reason for denial)	
Approved by: ☐ Frank Salmon, Chief Medi-Cal Oversight-North/ Cathy Bishop, Designee ☐ Tom Burke, LCSW, Chief Medi-Cal Oversight-South/ Kathy Schramm, Ph.D. Designee	
Signature of Chief/Designee:	Date:

This waiver is effective the date a complete waiver application was received in the Medi-Cal Oversight regional office or the date of employment, whichever is later. It is not retroactive to the date of hire.

This waiver is granted pursuant to Welfare and Institutions Code Section 5751.2 and with the stipulation that the employer and the applicant assume responsibility for meeting all applicable statutory and regulatory requirements during the approved waiver period.

Appendix N
Data Requirements

This procedure applies only to providers approved for MAA Claiming.

Medi-Cal Administrative Activities (MAA) Procedures

MAA activities in mental health are governed by a set of procedures. These procedures are described in detail in the MAA Instruction Manual developed by the State Department of Mental Health, and are summarized below.

The Claiming Plan

In order to participate in MAA, the County must submit a Claiming Plan to the State for approval by the last day of the quarter in which the first invoice will be submitted. Using a standardized format developed cooperatively by the State and Federal Medicaid agencies, the MAA Claiming Plan must describe in detail each of the MAA activities for which claims will be submitted, by job class. The standardized format can be found in the California Department of Mental Health MAA instruction manual.

The Claiming Plan also describes the units that will be participating in MAA, the type of supporting documentation that will be maintained, and the development and documentation of costs relating to MAA. It indicates which activities will be focused entirely on the Medi-Cal population. If the activities will be focused on a larger population, the Claiming Plan must describe the methodology that will be used to discount the claim by the percentage of Medi-Cal eligibles in the population.

The State Department of Mental Health has established procedures for amending the MAA Claiming Plan. It has also developed a Claiming Plan checklist and a checklist to use when submitting amendments to the Claiming Plan. Copies of these documents, along with a copy of the most recently approved version of the plan, are on file in the Mental Health Plan administrative offices. Claiming plans and any amendments will remain in effect from year to year. A Claiming Plan will not need to be amended, unless the scope of MAA is significantly changed or a new type of activity is undertaken. For example, a Claiming Plan must be amended when a new outreach campaign or program is instituted, or a new claiming unit performing MAA is created.

Claiming Procedures

Claims for MAA reimbursement are submitted quarterly to the State Department of Mental Health (DMH) by HHSA. A detailed quarterly invoice is prepared for each mental health unit participating in MAA, as identified in the claiming plan. County-operated programs are one unit; each participating contractor is a separate unit. A summary invoice is also prepared that aggregates all invoices submitted by mental health. An approved claiming plan covering the period of the claim must be in place before an invoice may be paid.

The County is required to provide DMH with complete invoice and expenditure information no later than December 31, following the fiscal year for which a claim is submitted. Invoice and expenditure information must be submitted to DMH prior to or with the County's cost report for the current fiscal year. DMH may approve the claim, return it for correction and/or revision, or deny the claim. The County may request reconsideration of a denied claim in writing within 30 days of receiving the denial.

The detailed quarterly invoice captures the time spent on MAA, the Medi-Cal percentage, expenditure and revenue information on a single spreadsheet.

MAA Training

All staff participating in MAA, and completing MAA activity logs, will attend MAA training sessions on at least an annual basis. Sign-in sheets will serve as a record of the individual's attendance. Training will be scheduled and provided at the direction of Mental Health Administration.

Reporting MAA Activities

MAA activities are reported to InSyst. The reporting requirements are somewhat different than what is required for direct services. For MAA, staff must report the following each time an MAA activity is performed:

- the day the activity occurred;
- the activity code (as a proxy for the name of the activity);
- the number of minutes spent on the activity;
- the name of the employee performing the activity.

A standardized MAA Activity Log has been developed; however, programs can develop their own as long as it contains the essential MAA reporting information. When programs develop their own form, they should forward it to the MAA Coordinator to ensure it covers the basic elements. The standardized forms are included as Attachments 1 and 2. Each activity log is to be signed by the employee before he/she gives it to the clerical staff responsible for entering data into InSyst Mental Health MIS. Activity logs may cover multiple days. Completed logs should be signed by the employee, and turned in to the person responsible for entering the information into InSyst on a timely basis, but no later than the fifth working day after the end of each month.

Document Retention

The County of San Diego has adopted a record retention policy that requires these records to be retained for seven (7) years. Program managers are responsible for storing signed, original versions of all MAA activity logs, outreach materials, and all documentation that supports the MAA claimed by their staff.

Becoming an InSyst User

Information on the amount and type of MAA activity performed by individual staff is entered into InSyst. Anyone who performs MAA activities needs an InSyst User ID so these activities may be entered into InSyst. Staff who provides direct services have InSyst identification numbers. Administrative and clerical staff who perform MAA activities will need an InSyst ID number as well. These ID numbers may be secured by calling UBH.

Quality Assurance; Monitoring

The quality of the MAA program will be monitored through quarterly reports from InSyst. The Mental Health Services MAA Coordinator will disseminate these reports to program managers, notifying them of any identifiable discrepancies found. These reports will provide managers with summaries of the amount of time reported to all MAA activities, by staff name. Program managers are expected to use the monitoring reports to:

- ensure that staff is reporting their MAA time accurately, using the correct activity codes;
- ensure that all staff that should be reporting MAA is doing so;
- ensure that MAA time is being reported consistently among staff in same classification.

Managers are required to ensure that corrective action is taken on any discrepancies they find or that have been identified by the MAA coordinator. Random reviews will take place to ensure that staff is reporting MAA correctly.

The MAA Audit File

An MAA audit file will be maintained at Mental Health Administration, and includes the following:

- a copy of the most recently approved MAA claiming plan for the County and for each participating contract agency;
- copies of current SPMP forms, and verification that each SPMP's license, where applicable, is current;
- job descriptions and/or duty statements for all staff participating in MAA;
- electronic or hard copies of the raw data used to calculate each quarterly percentage of MAA activity;
- electronic or hard copies of the reports used to establish the Medi-Cal percentage for each quarterly MAA claim;
- locations (with addresses) where MAA activity logs are kept on file, and where copies of information used in outreach or eligibility assistance activities are kept;
- copies of annual training schedules, training rosters, and materials used in training.

Who Can Claim MAA: An Overview

Clinical staff

- MAA may be used for client-based activities that are not part of a direct service or that are provided to an individual who does not have an open case anywhere within the system. MAA also includes outreach activities to inform individuals or groups about the availability of Medi-Cal and mental health services.

Administrators

- MAA includes program planning and contract administration.
- MAA includes outreach activities to inform individuals or groups about the availability of mental health services.

Clerical staff, Human Service Specialist and all other staff

- MAA includes activities that assist individuals, regardless of their case status, to apply for Medi-Cal or to access services covered by Medi-Cal.
- MAA activities include the administrative support clerical staff provide around outreach, contract administration, program planning, and crisis situations.

The MAA Activity Codes

A set of MAA activity codes has been developed for local mental health programs. The activities include:

Activity Code	
401	Medi-Cal Outreach
457	Mental Health Outreach
404	Facilitating Medi-Cal Eligibility Determinations
481	Case Management of Non-Open Cases
451	Referral in Crisis Situations – Non-Open Cases
409	MAA Coordination and Claims Administration

MAA Activity Code Definitions

401 Medi-Cal Outreach – This code may be used by all staff in county and contract programs. Includes the following:

- informing Medi-Cal eligibles or potential Medi-Cal eligibles about Medi-Cal services, including Short-Doyle/Medi-Cal services;

- assisting at-risk Medi-Cal eligibles or potential Medi-Cal eligibles to understand the need for mental health services covered by Medi-Cal;
- actively encouraging reluctant and difficult Medi-Cal eligibles and potential Medi-Cal eligibles to accept needed health or mental health services;
- performing information and referral activity that involves referring Medi-Cal beneficiaries;
- referring Medi-Cal eligibles to Medi-Cal eligibility workers.

457 Mental Health Outreach – This code may be used by all staff in county and contract programs. Includes the following:

- informing at-risk populations about the need for and availability of Medi-Cal and non-Medi-Cal mental health services;
- providing telephone, walk-in or drop-in services for referring persons to Medi-Cal and non-Medi-Cal mental health programs.

404 Facilitating Medi-Cal Eligibility Determinations – This code may be used by all staff in county and contract programs. Includes the following:

- screening and assisting applicants for mental health services with the application for Medi-Cal benefits.

481 Case Management of Non-Open Cases – May be used by all staff in county and contract agencies. Includes the following:

- gathering information about an individual's health and mental health needs.
- assisting individuals to access Medi-Cal covered physical health and mental health services by providing referrals, follow-up and arranging transportation to health care.

451 Referral in Crisis Situations - Non-Open Cases – May be used by all staff in county and contract programs. Includes the following:

- intervening in a crisis situation by referring to mental health services.

409 MAA Coordination and Claims Administration – This code may be used by all staff in county and contract programs. Includes the following:

- MAA Training

NAME:
STAFF NUMBER:

SAN DIEGO COUNTY MENTAL HEALTH

ORGANIZATIONAL PROVIDERS MAA ACTIVITY CODES

DATE	Medi-Cal Outreach			Mental Health Outreach			Medi-Cal Eligibility Intake			Non-SPMP Case Management of Non-Open Cases			Referral in Crisis Situation - Non-Open Cases			MAA Coordination and Claims Administration		
	401			**457**			**404**			**481**			**451**			**409**		
	MINUTES		DAILY TOTAL	MINUTES		DAILY TOTAL	MINUTES		DAILY TOTAL	MINUTES		DAILY TOTAL	MINUTES		DAILY TOTAL	MINUTES		DAILY TOTAL

Instructions: Fill in identifying information. Enter date and all MAA activity for that date. Record all activity in minutes. There are 4 cells for each date, use one cell for each activity. If you need more than 4 cells on a given day, start a new row. Enter a daily total in minutes.

401 - Medi-Cal Outreach - Informing Medi-Cal recipients or potential eligibles about Medi-Cal services, assisting them to understand the need for services.

457 - Mental Health Outreach - Informing at-risk populations about the need for and availability of Medi-Cal and non-Medi-Cal mental health services.

404 - Screening and assisting applicants for mental health services with the application for Medi-Cal benefits.

481 - Gather information about an individual's health and mental health needs and assisting individuals to access Medi-Cal physical health and mental health services by providing referrals, follow-up, and arranging transportation for mental health care.

451 - Intervening in a crisis situation by referring to mental health services.

409 - MAA Coordination and Claims Administration - Drafting, revising, and submitting MAA Claiming Plans. Serving as liaison with claiming programs within the LGA and with the state and federal governments on MAA. Monitoring the performance of claiming programs. Attending training sessions, meetings, and conferences involving MAA. Training staff on state, federal, and local for MAA claiming. Ensuring that MAA claims do not duplicate Medic-Cal claims for the same activities from other providers.

Signature _____

Appendix O
Training/Technical Assistance

Appendix P
Adult AB 2726 Services

Instruction Sheet for Quarterly Progress Mental Health IEP Report

This report is completed by the outpatient provider on a quarterly basis. It lists the progress towards the goals outlined on the Mental Health Treatment Plan (see *Appendix P*). This report is sent to the school contact (whomever is identified) and a copy is given or sent to the client. This report could be sent to the parent also if there is a release of information present and if the client agrees. The original report is maintained in the "Plans" section of the client's chart.

QUARTERLY PROGRESS MENTAL HEALTH IEP REPORT

Program: _____

Address: _____

Telephone: _____

Patient Name:	**DOB:**
Therapist:	
Reporting Period: to	

Progress Rating:
1-Goal not met; symptoms stayed the same or got worse
2-Goal not met completely, but some progress made (1-50% of goal achieved)
3-Goal not met completely, but substantial progress made (51-99% of goal achieved)
4-Goal met or exceeded (100% of goal achieved)

GOAL # 1:

Progress: 1 ☐ 2 ☐ 3 ☐ 4 ☐

Comments on goal/progress:

GOAL # 2:

Progress: 1 ☐ 2 ☐ 3 ☐ 4 ☐

Comments on goal/progress:

GOAL # 3:

Progress: 1 ☐ 2 ☐ 3 ☐ 4 ☐

Comments on goal/progress:

Scheduled Frequency of Sessions: **Weekly** ☐ **Bi-Weekly** ☐ **Monthly** ☐

Concerns with Attendance: No ☐ Yes ☐

Date of Contacts with School:

_____ _____

Therapist Signature **Date**

Adult AB2726 Clients

Instruction Sheet for Mental Health Treatment Plan

When an outpatient (OP) clinic receives the AB2726 referral, the Special Education Services (SES) clinician making the referral has completed this Mental Health Treatment Plan. This plan guides the OP provider's client plan, as treatment goals need to be consistent. This Mental Health Treatment Plan is placed in the "Plans" section of the chart and is to be updated at each Benchmark/Short-Term Objective as outlined on the Plan. The Measurable Long-Term Goal has a six-month duration, because services on the Individualized Education Plan (IEP) are only valid for 6 months. After 6 months, a new Mental Health Treatment Plan with updated goals is to be written. At this point, there needs to be an IEP meeting to discuss continuation of services and to review and accept the updated goals. (Note: to reconvene an IEP meeting, the outpatient provider completes a Need for IEP Review-labeled as attachment #4- and forwards it to the school contact). The IEP review process could be completed by mail (rather than a formal meeting) if the client agrees, since they are 18 or over. The district could do an action form that states services will continue for 6 more months and the IEP team is in agreement with the goals. Once everyone signs the updated IEP, the provider needs a copy for the client's medical record. This six-month process continues until AB2726 services are discontinued.

*Please note that the form indicates when and how parents (or adult client) will be informed of progress on this treatment plan. These are the guidelines to follow in addition to the six month IEP process listed above.

**Be aware that the six-month updates to the standard OP provider client plan are also required for these clients.

COUNTY OF SAN DIEGO
HEALTH AND HUMAN SERVICES AGENCY
SAN DIEGO MENTAL HEALTH SERVICES

MENTAL HEALTH TREATMENT PLAN

Date: **Student:** **Type of Service:** **Start Date: ASAP** **Duration: 6 months**

Area of Need:

Present Level

Measurable Long-Term Goal:

Parents will be informed of progress	**Periodic Review Dates**	**Progress Toward Goal**	**Sufficient Progress to Meet Goal**
☒ Quarterly ☐ Trimester	1.	1.	☐Yes ☐No
☐ Semester ☐ Other:	2.	2.	☐Yes ☐No
How ?	3.	3.	☐Yes ☐No
☐ Annotated Goals/Objectives	4.	4.	☐Yes ☐No
☒ Other: teacher, therapist			

Benchmark/Short-Term Objective: Within 2 months:
1.

Date:
☐ Achieved
☐ Reviewed

Person(s) Responsible: client, therapist

Benchmark/Short-Term Objective: Within 4 months:
1.

Date:
☐ Achieved
☐ Reviewed

Person(s) Responsible: client, therapist

Area of Need

Present Level:

Measurable Long-Term Goal:

Parents will be informed of progress	**Periodic Review Dates**	**Progress Toward Goal**	**Sufficient Progress to Meet Goal**
☒ Quarterly ☐ Trimester	1.	1.	☐Yes ☐No
☐ Semester ☐ Other:	2.	2.	☐Yes ☐No
How ?	3.	3.	☐Yes ☐No
☐ Annotated Goals/Objectives	4.	4.	☐Yes ☐No
☒ Other: teacher, therapist			

Benchmark/Short-Term Objective: Within 2 months:

Date:
☐ Achieved
☐ Reviewed

Person(s) Responsible: client, therapist

Benchmark/Short-Term Objective: Within 4 months:

Date:
☐ Achieved
☐ Reviewed

Person(s) Responsible: client, therapist

Student Signature *Date* *Signature of Parent* *Date*

Signature of Mental Health Service Representative *Date*

Instruction Sheet for Need for IEP Review Form

The outpatient provider completes this form when an Individual Education Plan (IEP) meeting needs to be scheduled. Please note that there are multiple reasons for a meeting to be held. This form is forwarded to the school contact (whomever is identified) and a copy is maintained in the "Correspondence" section of the client's medical record.

COUNTY OF SAN DIEGO
DEPARTMENT OF HEALTH SERVICES
MENTAL HEALTH SERVICES

NEED FOR IEP REVIEW

TO: _____DATE:_____

FROM: _____ TELEPHONE _____

RE: _____ DOB: _____

A. We are unable to continue our delivery of mental health assessment services to your pupil _____, for the following reason:

_____1. Parent has not signed a mental health assessment plan.

_____2. Parent has failed to come in for scheduled assessment visits.

_____3. Parent has withdrawn permission for the mental health assessment.

_____4. Other/comments _____
_____
_____
_____

B. This is to notify you of a substantial change to the IEP/Treatment Plan because:

_____1. Client has completed treatment.

_____2. Client is in need of change in mental health services level of care.

_____3. Child is not benefiting from his mental health services.

_____4. Parent no longer wishes to have treatment services identified on the IEP for the child through Short-Doyle/MHS.

_____5. Parent has had difficulty following through with the treatment plan.

_____6. Parent has moved to another district/SELPA

Other/comments_____
_____
_____
_____

cc: Chart A.P.7

Appendix Q
Quick Reference

Appendix R
MENTAL HEALTH SERVICES ACT - MHSA